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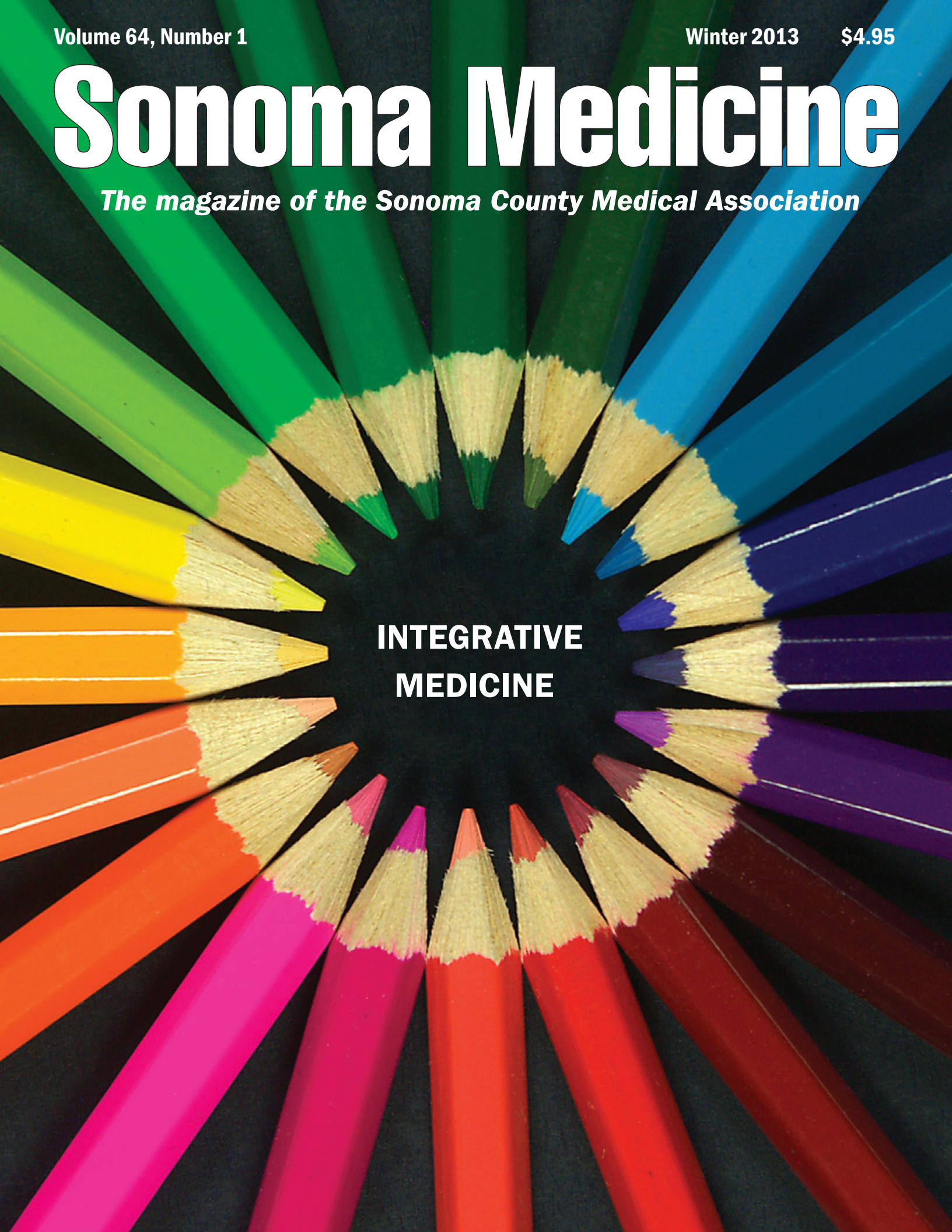
The magazine of the Sonoma County Medical Association



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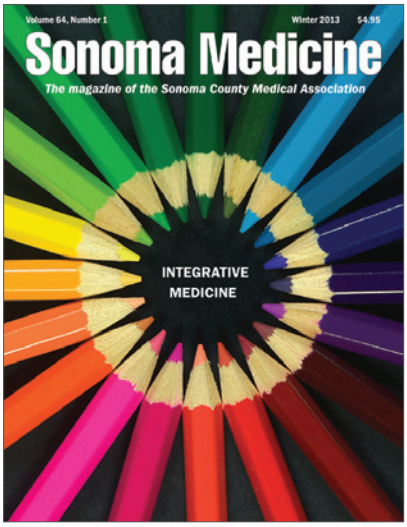

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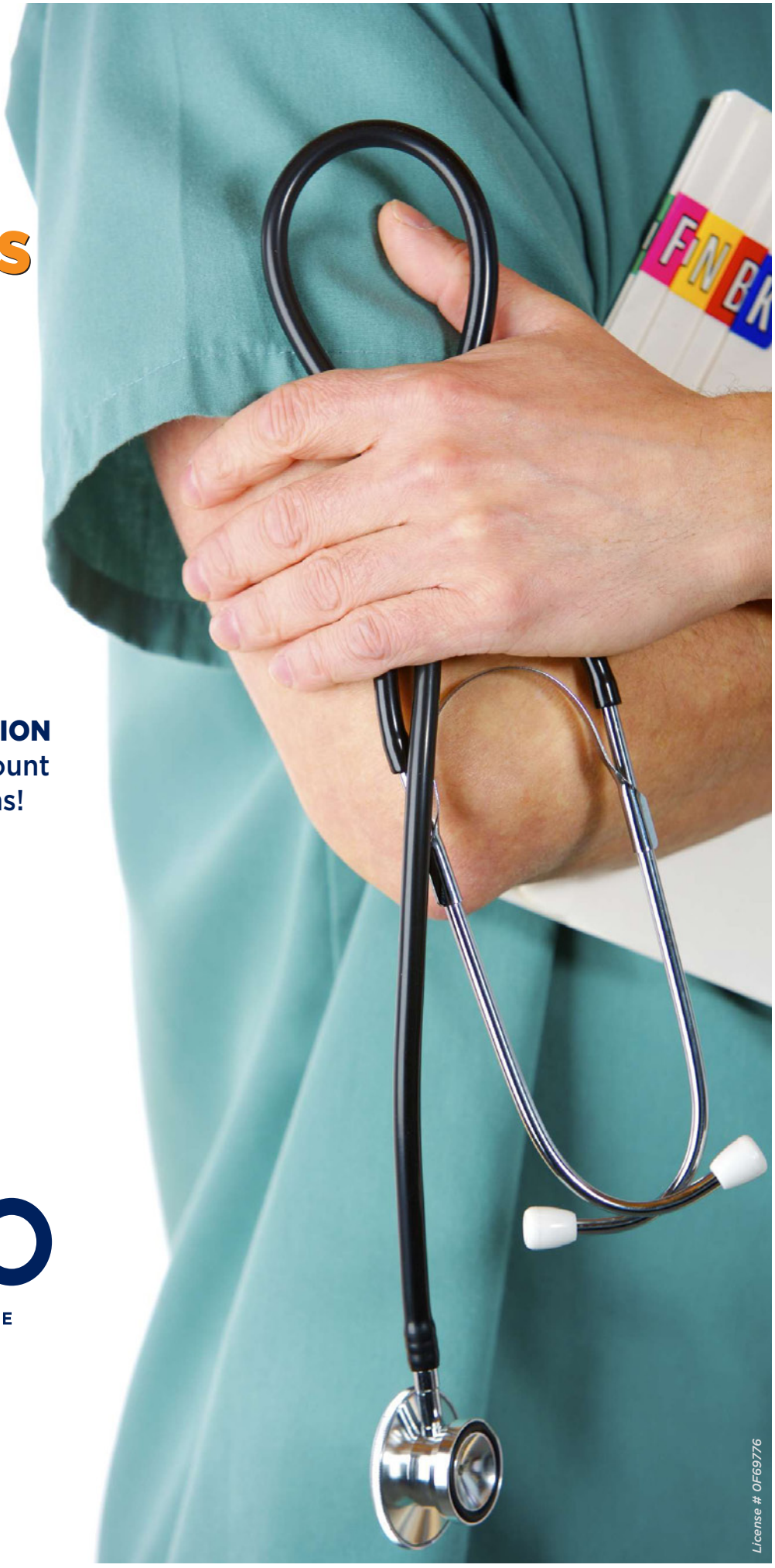

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More Tools for Our Toolbox

Jessica Les, MD, MSc

Growing up I recall thinking, as many of us do, that Western medicine had an answer for most ailments. But then in high school I witnessed a handful of loved ones with conditions where Western medicine offered nothing. Through their experiences, I had my first glimpse of the wide world beyond Western medicine—but for my middle class community in Wisconsin, those options seemed beyond reach. Throughout college, and then graduate school in public health, I thought that non-Western, "integrative" medicine was an elite privilege, so I paid little attention to it.

Then I started medical school at Stanford, and my opinion of integrative medicine changed. By the end of my first clinical year, I realized the gaps in Western medicine were larger than I thought, and the treatments we do offer, even if effective, usually carry side effects. Western medicine shines in certain areas: infectious disease, acute pain, conditions amenable to surgical treatment, cervical cancer screening, trauma and dialysis. But what about other maladies? And what about all the patients already seeking integrative medicine in the United States?

A little research at that time revealed that in 2007, 38% of Americans were already using integrative medicine. A series of focus groups during that same year demonstrated that most patients want to discuss their use of non-Western modalities with their medical doctors. Yet I learned nothing in medical school to address these issues, and I found myself grasping for knowledge to fill the gaps.

Dr. Les, a family physician, serves on the SCMA Editorial Board.

Then an opportunity arose—an elective month at Sri Aurobindo Ashram in New Delhi, India. The ashram ran a free clinic that offered Western medicine, naturopathy, homeopathy and ayurveda to the poor via volunteer practitioners of each discipline. I would also have the opportunity to talk to doctors at the University Hospital, in private practice, and in rural clinics. I hoped to gain insight into how and what medical care is accessed, and by whom.

A month later, I returned home with some surprising lessons that now seem logical. The norm in India is to use different healing modalities for different ailments. If you have a cold or a breathing problem, you seek homeopathy. If you have a weight problem, general malaise or a non-infectious gastrointestinal ailment, you seek naturopathy and/or ayurveda. If you have a serious infection, broken bone, tumor or difficult birth, you seek Western medicine. This pattern seemed to cut across socioeconomic strata, with the harsh caveat that the rural poor had limited access to Western medicine beyond vaccines.

I returned to Stanford not convinced by every healing practice I witnessed, but rather believing strongly in the concept of integrative medicine. During my subsequent training at the Santa Rosa Family Medicine Residency, I had the good fortune to learn from national integrative medicine experts and witness great benefits from thinking outside the Western medicine box for my patients. So when I was diagnosed with a breast cancer recurrence this summer, I decided that if I was going to talk the talk with my patients, I had better walk the walk for my own health. I sought Western medicine for my cancer treatment, but I have relied heavily upon acupuncture, nutritional counseling, reflexology and guided imagery to deal with the side effects that Western cancer treatment brings. Is my cancer team adept at all these modalities? No. Do they encourage me to use them? Absolutely.

Since my elective in India, I have come to think of integrative medicine as similar to parenting with the best intentions. In raising their children, parents don't depend solely upon school, or on providing food, shelter and clothing, or on bedtime reading, or on vaccinations, or on loving their child to pieces. Instead most parents want to use every tool available to help raise, support and nourish their child's body, mind and spirit. Why not do the same for your well-being, and that of your patients? Integrative medicine means using all tools available, not just Western medicine tools, to support health and ease suffering.

None of us can master all the healing modalities, nor should we. But we can be open-minded and inquisitive, build partnerships, and expand our own skill sets to provide the best care possible for our patients. In this issue of *Sonoma Medicine,* you will learn more about what integrative medicine encompasses and how it is being taught and delivered across Sonoma County. ◇

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What is integrative medicine?

Catherine Gutfreund, MD

So what is integrative medicine? Is it just a new buzzword of 21st century medicine popularized by Dr. Andrew Weil or is it a transformational way to practice medicine? I and many other physicians believe the latter.

Integrative medicine is a healing-oriented practice that takes account of the whole person (body, mind and spirit), including all aspects of lifestyle. It emphasizes the therapeutic relationship and makes use of all appropriate therapies, both conventional and alternative.

The principles of integrative medicine include:

- A partnership between patient and practitioner in the healing process.
- Appropriate use of conventional and alternative methods to facilitate the body's innate healing response.
- Consideration of all factors that influence health, wellness and disease, including mind, spirit and community, as well as body.
- A philosophy that neither rejects conventional medicine nor accepts alternative therapies uncritically.
- Recognition that good medicine should be based in good science, be inquiry driven, and be open to new paradigms.
- Use of natural, effective, less-invasive interventions whenever possible.
- Use of the broader concepts of health promotion and illness prevention, as well as treatment of disease.
- Training of practitioners to be models of health and healing, committed to the process of self-exploration and self-development.

Dr. Gutfreund, a former president of SCMA, is chief of integrative medicine at Kaiser Santa Rosa.

Integrative medicine does not shun conventional medicine. If you were in a serious accident, for example, you would want to be treated at a level one trauma center with the most up-to-date technologies. However, most health care treatments are for chronic conditions, and this is where integrative medicine can really improve outcomes and decrease costs. Integrative medicine focuses on health and healing instead of just disease symptom management. It is patient-centered care, with the patient being educated and empowered to be proactive and responsible for their own health and wellness. Their physician can work with them to develop a comprehensive plan for their chronic conditions to achieve optimal health. This type of planning is different from a "curative" approach, where a patient takes a pill or has a procedure to achieve health. In integrative medicine, healing often comes from a therapeutic relationship with the physician.

The integrative medicine movement got started in the 1990s after a study showed that one in three Americans had used an alternative therapy, often without their physician knowing about it.[1] Many patients are dissatisfied with a health care system in which doctors are rushed and overwhelmed and patients feel as if they are nothing more than diseased kidneys or worn-out joints. Integrative medicine seems to promise more time, more attention and a broader approach to healing, not based solely on the Western biomedical model.

Many of our patients are already using "unconventional" medicine for their health care needs, including acupuncture, Tai Chi, meditation or herbal supplements. We need to ask patients in a nonjudgmental way what they are doing and listen to why they are using those treatments. If we don't ask, they often won't tell us. We can become more helpful to our patients if we learn more about these therapies or supplements.

We should help direct our patients to optimal health and steer them away from treatments that may cause harm. To that end, more outcome-based studies and research are needed to document both the clinical- and cost-effectiveness of integrative versus conventional treatments for common health conditions. The gold standard "double-blind, placebo-controlled" model does not work well for evaluating many alternative therapies. We need more outcome-based studies, such as those already being done at the National Institutes of Health and at many academic medical centers.

The Consortium of Academic Health Centers for Integrative Medicine—which includes Duke, UCSF, Harvard and about 50 other esteemed academic medical centers and affiliate institutions—has developed because of the integrative medicine movement. The consortium supports the advancement of integrative healthcare curricula, research and clinical care and also disseminates information on scientific research and healthcare policy. Many residency programs now have integrative medicine curricula and fellowships.

In Sonoma County, we are lucky to have the Santa Rosa Integrative Family Medicine Fellowship, which has graduated four fellows to date.

At Kaiser Permanente, we believe in having our patients "thrive," and we have many online and class resources for mind-body medicine, stress reduction and healthy living. We offer acupuncture for our members, chiropractic for Medicare patients, and Tai Chi and massage for employees. We have a regional team of doctors from each of our facilities that meets regularly to help promote integrative medicine to our patients, physicians and staff. Our electronic medical record system connects with evidence-based alternative medicine information to help physicians care integratively for their patients. Over the past year at Kaiser Santa Rosa, I have run an integrative medicine clinic weekly with our medical students from Touro University. We soon will be expanding the clinic and also offering an osteopathic manipulation clinic.

We physicians must constantly keep up with new information and continue to learn throughout our careers in medicine. I would ask my colleagues to keep an open mind and consider learning more about integrative treatments to help their patients achieve optimal health. Possibly at some point in the future the "integrative" will be dropped from the title and just be considered good medicine. ◇

Email: catherine.a.gutfreund@kp.org

Integrative Medicine Resources

The National Center for Complementary and Alternative Medicine (www.nncam.nih.gov) was founded as part of National Institutes of Health to define, through rigorous scientific investigation, the usefulness and safety of complementary and alternative medicine interventions and their roles in improving health and health care.

The Natural Medicines Comprehensive Database (www.naturaldatabase.therapeuticresearch.com) offers unbiased scientific clinical information on complementary, alternative and integrative therapies. It lists effectiveness ratings and potential interactions with drugs.

The American Board of Integrative Holistic Medicine (www.abihm.org) offers courses in integrative medicine and provides board certification.

Some other great resources are:

University of Wisconsin Integrative Medicine Program: www.fammed.wisc.edu/integrative.

Arizona Center for Integrative Medicine: www.integrativemedicine.arizona.edu.

Integrative Medicine for the Underserved: www.im4us.org.

Reference

1. Eisenberg DM, et al, "Unconventional medicine in the United States: prevalence, costs and patterns of use," *NEJM*, 328:246-252 (1993).

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The Art of Integration in a Community Clinic

Fasih Hameed, MD

Interior of the Petaluma Health Center.

In 2009, the Petaluma Health Center (PHC) received a grant from the Obama administration to build a clinic that would allow us to practice a new kind of medicine in which team-based care, movement, shared medical visits, and complementary services would work together to provide optimal community health. At the time we called it "integrative medicine," for lack of a better term, but I have come to realize that true success comes from *integrated* integrative medicine—that is to say, all parts of the clinic must share the same common goal of optimal patient health and work together as an integrated team to achieve that end.

PHC hired me in 2009, just after I completed my fellowship in integrative medicine at the Santa Rosa Family Medicine Residency, to make integrative medicine services available to patients. Only now, three years later, are we finally close to integrated integrative medicine. A few key factors have made this possible:

Time. Change takes time. When I was hired, there were essentially no integrative services at PHC. We started with a simple chronic pain shared medical visit, and as providers became more comfortable with referring patients to these visits, we were able to slowly grow the offerings. If we had rolled out 10 new services at once, we would have confused everyone, and the program would have failed (more on this later).

Dr. Hameed, a family physician, directs integrative medicine at the Petaluma Health Center.

Provider passion. The administration at PHC is amazingly receptive and supportive of provider-led, passion-based innovative care models. If a provider is inspired to offer a new shared medical visit or spearhead a wellness initiative, they are encouraged to do so.

Team thinking. This type of thinking is important at every level. Medical assistants, nurses, providers, patients, front office . . . everyone involved needs to recognize the importance of comprehensive, whole-person care. At PHC we use a team-based model of care where the emphasis is taken off the provider and more of the patient interaction is shared by the team, which includes the medical assistants, nurses, referral specialists, health information specialists, patient navigators, and providers. Since we have started this model, it seems that we are more likely to consider other aspects of the care team as potential therapeutic options. Once we realize that we are not individuals working in a silo, but rather members of a large team of care providers, we feel more comfortable sending patients to wellness services or calling for assistance from patient navigators, diabetic educators or mental health specialists. It feels like we are all working together to help the patient succeed.

A wellness manager (and a scheduler). It seems like a big step, and it is, but hiring a manager to oversee the wellness services and designating one person to do all of the scheduling and call-backs for our various programs has made a tremendous improvement in our attendance. Prior to our manager, I was responsible for much of the oversight of our wellness services, and it was too much for a full-time physician to handle. As director of integrative medicine, I work closely with the manager to ensure that our policies and procedures are appropriate and that the quality of our services meets the needs of our patients.

The space. PHC is designed with wellness services in mind. The center of the clinic is home to a spacious movement room, a large dividable group room, a partially constructed demon-

stration kitchen, and the collaboration room, where providers go to work on projects individually or in groups. There is another large room that accommodates the six Lafuma recliners necessary for group acupuncture. There are also small group rooms in each medical pod. The colors and motifs throughout the building were chosen to inspire healing. Outside, there is a 5,000 square-foot vegetable garden that we made by sheet-mulching a section of the existing lawn, with help from Daily Acts, the City of Petaluma, Chris Reamer, and many other individuals and organizations.

Getting the word out . . . to providers, patients and staff. As services grow, it becomes difficult to keep everything straight. Streamlining referral processes and having centralized calendars with wellness schedules promotes use. We have had to reinvent this wheel many times. We now have binders in every patient room with patient education materials as well as information on all of the wellness services we offer at PHC.

So what are those services? For starters, we offer numerous shared medical visits for patients with chronic disease, chronic pain, anxiety, depression, stress-mediated illness and tobacco dependence. We have also developed an innovative pediatric wellness program called PLAY (Petaluma loves active youth), which partners with our local nonprofit farm, Petaluma Bounty, to provide healthy food to select participants.

Our prenatal program provides classes in both English and Spanish, and there is even a weekly prenatal exercise group. Acupuncture is available in a modified group setting by licensed medical providers. We also have three nutritionists who use a practical, functional approach to healthy eating. Like PLAY, they distribute local, organic produce from Petaluma Bounty.

We offer low-cost community exercise classes in Zumba and yoga. These classes are open to all members of the community, though PHC patients pay a reduced rate. We are also starting to offer more peer-led support groups. Our first such group is open to the LGBTQ community. Because wellness begins within, we are proud to offer staff wellness options such as free meditation classes, free massage, gardening, and discounts on Zumba and yoga. The garden we installed grows vegetables to help provide healthy food for our patients. We had a banner first season, with tomatoes overflowing by the end.

Finally, I offer integrative medicine consults. I see the patient for a one-hour consult, and we develop a comprehensive wellness plan. We focus on goal setting and usually work on the foundations that affect all illness: sleep hygiene, stress management, good food, movement, healthy habits, and strong community and connection. Follow-up is either through phone or brief office visit.

What's all this talk about wellness, vegetables and exercise? Wellness is a big part of integrative medicine. So are vegetables, and movement therapies, and metformin. There may be a misconception out there that integrative medicine is some fancy thing that involves lots of supplements and teas, powders and tinctures, reiki and magnets and homeopathy and odd lab tests. It may be. But for the average person, and especially for patients who come to community health centers like PHC, integrative medicine is about seeing the patient as a whole person and helping them move past the barriers that are preventing them from being well. It doesn't make much sense to pay for expensive supplements or therapies if you aren't eating breakfast or engaging in regular physical or stress-reduction activities. For the most part, the simpler lifestyle interventions are more effective, more evidence-based and more cost-efficient than supplements or therapies.

Integrative medicine does not exclude interventions based on origin. If a therapy is safe and effective, it is an option. This inclusive approach allows integrative medicine to be culturally sensitive and approachable for a broad audience, such as patients seen at a community health center. Perhaps it is this inclusivity that explains integrative medicine's wide appeal. Sometimes you need a drug, but at other times you just need a bowl of soup and a good night's sleep, or a hug from a loved one. It's hard to imagine labeling these things as integrative medicine, but they do fall into the pillars of lifestyle that create wellness: food, sleep/rest, community/connection, stress reduction.

When you think of integrative medicine like this, it becomes more acceptable to the average physician. What we are describing begins to sound less like an alternative, and more like a necessary part of "good" medicine. I guess that's why, at the Petaluma Health Center, we've made our motto "The Center for Good Health." After three years of change, I think we're finally getting pretty close to an integrated model that works. ◇

Email: fasihh@phealthcenter.org

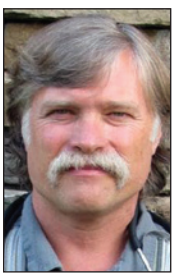
A Working Model for Integrative Health

Gary Pace, MD

In Sonoma County, we have many talented alternative health practitioners, a group of committed, pioneering integrative medicine physicians, and a patient population that regularly chooses complementary modalities to care for their families. The county is emerging as a hotbed of activity in bringing integrative medicine to underinsured and lower income patients.

West County Health Centers—a federally qualified health center with primary care sites in Occidental, Guerneville and Sebastopol—opened the Forestville Wellness Center in June 2011. With the forward-thinking leadership of West County Executive Director Mary Szecsey and Medical Director Jason Cunningham, MD, the Forestville site was opened with the express goal of bringing integrative medical services to our patients. As we move into our second year, we are excited about our offerings, and we plan to increase our hours from half-time to full-time in March.

In our model, integrative care includes a variety of alternative services, such as acupuncture and herbs, as well as education and support groups to help with improving the lifestyle patterns that contribute to chronic disease. The beauty of "integrative" care in our setting is that the services are not in opposition to conventional care, but rather work in conjunction with Western medicine.



Dr. Pace, a family physician, is medical director of the Forestville Wellness Center.

A brief overview of some of the pressing issues facing our current healthcare system illustrates the importance of experimenting with new models of care.

Shortage of primary care providers. The American Association of Medical Colleges projects a shortage of 45,000 primary care physicians nationwide by 2020; estimates surpass 100,000 with implementation of the Affordable Care Act.[1]

Ineffectiveness of conventional medicine for common primary care diagnoses. According to the National Ambulatory Medical Care Survey, the "top 5 primary care problems" are cough, sore throat, earache, back problems and skin rash.[2] Physicians will recognize that for many of these issues, we don't have especially useful interventions. In contrast, some alternative practitioners do find efficacy for these conditions with herbs and other modalities. Many patients use alternative treatments for common problems and appreciate informed guidance in their use.

Expense. The U.S. healthcare system is by far the most expensive in the world.

Insurance coverage. By many accounts, almost 50 million Americans are uninsured.

Health outcomes. While the U.S. leads the world in spending on healthcare, countries that spend far less per capita than the U.S. have healthier populations.[3]

Satisfaction. A recent survey of sicker American adults showed that 44% were "not very" or "not at all" satisfied with their healthcare system.[4] In addition, 50% of the hospital administrators surveyed were dissatisfied with the healthcare system.

Interest in alternative medicine. According to a nationwide survey, 38% of American adults use complementary and alternative medicine for wellness or to treat illness.[5]

Energy usage. Health care organizations spend over $6.5 billion in energy use per year. According to Clark Reed, director of the healthcare facilities division of the EPA, healthcare facilities are the second-most energy intensive commercial buildings, just behind food services.[6]

Medical waste. Because of the importance of sterility and preventing contagion, medical waste is a huge issue, gradually taxing landfill and medical waste disposal capacities. Dioxins (a known carcinogen) were until recently a major byproduct of medical waste incineration. Radioactive waste from diagnostic studies and treatments continues to be a disposal challenge.

With these considerations in mind, the Forestville Wellness Center was formed with the following mission statement: "We, at the Forestville Wellness Center, believe that each person's health is a unique journey. Through collaborative and sustainable partnerships between patients, practitioners of alternative and traditional medicine, and the greater community, we strive to provide a holistic and integrative model of care to our West County Health Centers patients and community."

We are striving to provide a variety of alternative health services to patients referred from our primary care sites. (At this point, none of these services are open to the community at large.) Patients referred include both those whose symptoms are not responding to conventional therapies and those who are not interested in pursuing conventional treatment. The wellness center's programs are designed to support the goals of these patients' primary care providers, and the patients continue with their primary care site as their "medical home."

Since Sonoma County is so rich with resources for healthy living and alternative healing, we have been fortunate to collaborate with many different local groups and practitioners in developing and offering our services, which include:

Western herbalism. Advanced students at the California School of Herbal Studies in Forestville work with our patients in a consult setting with physician oversight.

Acupuncture. Two professional acupuncturists have generously agreed to see some of our patients in their practices on a sliding-scale basis. We also have two physicians with training in acupuncture providing services in group and individual settings.

Homeopathy. One of our doctors offers classical homeopathy.

Osteopathy. We have a practicing osteopath working two afternoons a week.

Ayurveda. We are currently speaking with local Ayurvedic practitioners about getting these services available.

Integrative consults. We have two physicians on site with training in integrative medicine, both certified by the American Board of Integrative Holistic Medicine. In these consults, the patients explore lifestyle change and consider a combination of conventional and alternative therapies.

At this point, demand for most of these services is much greater than the supply, so the wait list can be as long as six months. We expect that our increase to full-time hours in March will help to decrease this backlog.

Isolation and disempowerment are two issues that seem to contribute to many of our patients' chronic disease states. We have also noticed the limited efficacy of medical providers to catalyze significant behavior change in diet and exercise during the brief primary care visit. Small groups that combine teaching, hands-on learning, peer support, goal setting and accountability are proving to be much more beneficial.

Over the last year, we have been fortunate to work with the Northern California Center for Well-Being. Their instructors have run groups at our site for smoking cessation, chronic pain management, diabetes management and meal planning. The Center for Well-Being has a structured, evidence-based program that has proven to be effective and appreciated by our patients.

Access to substance abuse treatment has also been increased by an affiliation with the Drug Abuse Alternatives Center. They offer individual and group sessions for our patients and others from the community who often cannot afford such services. We also have an ongoing support group for opioid-dependent patients who are using suboxone as a replacement therapy.

Most recently, we have started some flexible groups that focus on diet and nutrition, movement and exercise, and stress reduction. We are excited about the preliminary results, because the aim is to get patients involved and to set goals that are relevant to them. The group of peers then becomes the main resource for information, support and accountability.

These classes first started in collaboration with the Ceres Community Project, a food advocacy group. Their teachers have been coming twice a month, providing instruction and demonstration of healthy eating based on a whole-food, anti-inflammatory diet. A few months ago, WHOA Farm in Santa Rosa began offering fresh, organic produce to people who were trying to make dietary changes, and now each participant in the nutrition group gets a bag of fresh produce at the end of class.

At this point, the classes have grown to 15 people. Folks come early and stay late, engaging in lively discussions about diet. We basically have to start locking doors at the end of class to get them to leave. Several people are reporting marked changes in dietary choices, and they anecdotally claim to be experiencing significant improvements in the way they feel.

A push came from some of these patients for a more concerted support program to make more substantial lifestyle changes. In response, our group coordinator Mary Wyman, FNP, recently developed an 8-week course that supports more mindful eating habits and attempts to change a person's relationship with food. She brings in guest teachers, and they are setting goals and using subsequent classes for accountability.

All told, patients are progressing from a beginning experience of healthy food at the Ceres classes, to engaging in groups where we can help them deepen lifestyle changes that will make a long-term difference in their health. A future project will be to develop a 3-month, high-intervention group that combines diet, exercise and stress management with individual and group work, and with increased availability of healthy food. The goal is to see if we can help bring about more comprehensive shifts in the motivated but "unable to change" patient.

Our current approach to financing is to fold most of our services into a regular medical billing model.

At the West County primary care sites, if a medical provider sees a patient for diabetes and talks about diet and exercise as interventions, we bill without any problems. At the Wellness Center, we are doing the same thing, only the provider has help with most of the diet and exercise counseling. We team up with experts in these fields to discuss, demonstrate and get the patients actively involved in their care. All of this is done with medical oversight and with tailoring the recommendations and interventions to the patient's specific needs.

Measuring outcomes is our next focus. The first year has primarily been spent setting up programs and finding practitioners with whom we can collaborate. Now we are starting to incorporate pre- and post-intervention data collection and analysis. At this point, we don't have any results to share, but they should be ready by next year. Future plans include Spanish-speaking classes, more movement and yoga classes, and concrete approaches to stress reduction and management.

Does our approach address the problems with the healthcare system mentioned at the beginning of this article? That is a tall order, but we feel that our model offers potential guidance in developing solutions for these pressing issues. Potentially, we can lower the cost of care by intervening earlier to prevent the more expensive complications of disease. We can also decrease the pressure on primary care providers by offering a team approach that brings a more coordinated offering of expertise. We can likewise improve patient satisfaction and empowerment and decrease energy usage and medical waste.

The Forestville Wellness Center is one effort to create a viable model of integrative care. We are hoping to collect data within the next few years to better understand which parts are useful, and which can be discarded. The response of the patients and the staff has so far been very enthusiastic. ◇

Email: gpace@wchealth.org

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The Santa Rosa Integrative Family Medicine Fellowship

Ben Brown, MD, and Wendy Kohatsu, MD

Integrative Medicine fellows and faculty include (clockwise from bottom) Dr. Ben Brown, Dr. Rachel Friedman, Dr. Wendy Kohatsu, Dr. Fasih Hameed, Dr. Onna Lo, and Dr. Connie Earl. (Not pictured: Dr. Jimmy Wu.)

In order to enhance the health of our patients and communities, the Santa Rosa Integrative Family Medicine Fellowship is committed to training physicians to incorporate holistic principles into the delivery of effective care to diverse and underserved populations. The inspiration for creating this fellowship came from the demands of our patients and residents for integrative medicine. Now in its fifth year, the fellowship is a one-year, postgraduate training program where we emphasize making integrative medicine both accessible and affordable to any patient who wants it. Our motto is "Taking integrative medicine from the boutiques to the streets."

We are proud of our five fellows to date: Dr. Fasih Hameed, Dr. Onna Lo, Dr. Connie Earl, Dr. Rachel Friedman and our current fellow, Dr. Jimmy Wu. Each of them is making their mark in the world of integrative medicine in their communities.

Many people think integrative medicine consists only of natural therapies such as herbs, supplements and massage—but that is a relatively small part of what we do. Instead, we emphasize meeting patients' health goals and health challenges within the context of their lives by creating an ongoing treatment plan. The plan may include lifestyle change, changes to their living environment, changes in unhealthy relationships, shifting attitudes and beliefs, and using therapies, pharmaceuticals and surgery as needed to help meet these goals.

Lifestyle approaches empower people, and goal-setting clarifies needs and motivation. We have put these concepts together diagrammatically in the integrative medicine treatment pyramid (see illustration). Health is based on a foundation of patient-centered goals. Integrative medicine builds on that base by first employing lifestyle change, then including natural and conventional therapies when needed, all in the context of the patient's own environment and resources.

The Santa Rosa residency has long had a reputation for excellence. It is consistently ranked as one of the best family medicine residencies in the nation, and it attracts some of the country's brightest students. We are now gaining national attention for the integrative medicine fellowship.

Santa Rosa is the only residency program on the West Coast with an

Dr. Brown and Dr. Kohatsu, both faculty family physicians, codirect the integrative medicine fellowship at the Santa Rosa Family Medicine Residency.

integrative medicine fellowship, and it is the second in the nation to focus specifically on making integrative medicine available to the underserved. Our fellows have already made a powerful positive impact on local health care, and our faculty have made many presentations at national conferences. In November 2012, our fellowship was awarded full recognition by The American Board of Physician Specialties.

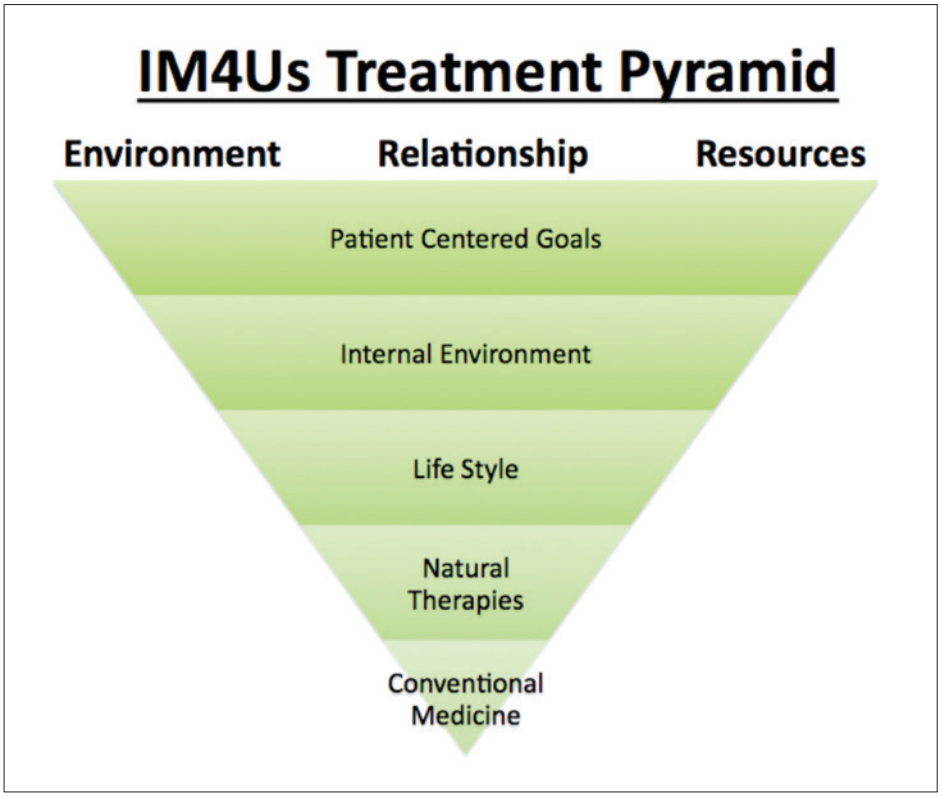
Integrative medicine activities at the residency program include a weekly integrative medicine consult clinic, acupuncture clinics, osteopathic manipulation, trigger-point therapy, and Tai Chi. We also offer one-on-one consults by the integrative medicine fellow and faculty within their own practice.

Regular clinic precepting by integrative faculty includes education for residents on using integrative therapies such as peppermint oil for irritable bowel syndrome, relaxation techniques for anxiety, and functional medicine testing for hypothyroidism. All residents receive longitudinal education on integrative medicine via biweekly lectures and participation in the integrative medicine consult clinic. Residents can also choose to pursue electives in integrative medicine.

Many patients have benefitted from our VeggieRx program, in which they receive prescription vouchers that they can redeem for fresh fruits and vegetables at local farmers markets.[1] We have also developed innovative group visits focusing on lifestyle change to engage patients in cooking demonstrations, group exercise, stress reduction and group sharing.

Two stories illustrate how we use integrative medicine when caring for patients (details have been changed).

"Joan" was a woman in her 50s, with obesity, former drug use, elevated glucose and frequent panic attacks. Through her own motivation and consistent encouragement from her physician for lifestyle change, she lost 30 pounds in four months after cutting out soda and exercising more regularly. She



The integrative medicine treatment pyramid.

Integrative medicine activities include cooking demonstrations.

had never tried relaxation methods before, but she responded amazingly well to deep breathing techniques, which substantially reduced her use of benzodiazepines and trips to the emergency department for panic attacks.

Sometimes when a physician has run out of options, he or she will send the patient to integrative care as a last resort. At this point the patient is often suffering so much they will try anything. One such patient was "Lupe," a woman in her 60s with increasing joint pain and negative rheumatology workup. She was failing her pain medicines and had started using a cane and losing sleep. She asked if there was anything else she could do to help her joint pain. Her integrative medicine physician started her on an elimination diet, where she was to avoid all dairy and gluten. Lupe came back a month later with a big smile on her face and no joint pain. She was now sleeping well and was no longer using a cane. She has remained pain-free as long as she avoids certain foods.

Though integrative medicine is not always this miraculous, it often fills the gap between what the patient needs or wants and what we have to offer. It is ideal for pre-pathologic states, early minor pathology (when the risks of medicines do not yet outweigh the benefits), and chronic illness, where our standard therapies often fall short. It offers the physicians of today and tomorrow an expanded set of evidence-based tools that they can use to help themselves, their families, and their patients get well and stay well. ◇

For more information on integrative medicine, including patient handouts and presentations, visit the Integrative Medicine for the Underserved website at www.IM4Us.org.

Email: benbmd@gmail.com

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Our Values

The values of the Santa Rosa Integrative Family Medicine Fellowship are multifaceted. They include:

Relationship based
Healing happens in the context of relationship.

Community connection
Meeting the needs of the population we serve.

Playfulness
Acknowledging the motivational and healing qualities of humor and play.

Openness
There is no one system that has all the answers.

Motivation
Working hard for positive change; willing to put in the effort it takes to bring a new idea to reality.

Balance
Finding the balance between professional passion and self-care.

Access
Healthcare is a universal right!

Effective care
Makes a positive difference in patients' lives

Sustainability
Solutions must be real-world practical.

Wellness
Live it, be it, teach it!

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Back to the Future?

Daymon Doss

In October 2002, Health Plan of the Redwoods announced that it was going to cease operations and file for bankruptcy. This regional HMO had served more than 100,000 members in Sonoma, Marin, Lake and Mendocino counties for more than 20 years, but it had been torn apart by dissension and overwhelmed by expenses.

Ten years later, in October 2012, Western Health Advantage received approval from the state Department of Managed Health Care for expanding into Marin, Napa and Sonoma counties. This not-for-profit HMO was founded in 1996 and currently serves 90,000 plus members in Solano, Yolo, Sacramento, Placer and El Dorado counties.

In the decade between these two events, healthcare delivery in Sonoma County has been transformed. With over 185,000 members locally, Kaiser Permanente has become the dominant provider, supplying coverage for about 40% of the county's residents. Kaiser has also made a strong play for the government marketplace. A significant majority of local government and education agencies and districts are currently aligned with Kaiser.

Sutter Health, the parent organization for Sutter Medical Center of Santa Rosa, continues to define its role in Sonoma County. The Sutter Pacific Medical Foundation, which includes the Sutter Medical Group of the Redwoods, is an effort to create a larger regional approach for a physician-based model. The limited success of managed care products—such as the Health Net "Silver Network" and the United Healthcare Medicare Advantage plan—has led to recent published accounts of Sutter Health filing for its own health plan to serve its model.

In 2009, the board of directors of the Petaluma Health Care District (PHCD) was convinced that a regional delivery system accompanied by a health insurance product was necessary to ensure the viability of non-Kaiser and non-Sutter physicians and facilities. Board members Dr. Stephen Steady and Dr. Robert Ostroff spearheaded a comprehensive review of southern Sonoma County delivery options by healthcare consultant Dr. Martin Serota. The review highlighted the need for a regional approach and reaffirmed the patient-driven, physician-led model as being essential to developing a successful process.

Drs. Steady and Ostroff endorsed, and the PHCD board authorized, the formation and funding of a Regional Access Plan that would include physician groups, independent physicians, and hospital systems. The physician groups included Marin IPA, Redwood Regional Medical Group, Annadel Medical Group, and Anesthesia and Analgesia Medical Group. Hospital systems participating included the Northern California Healthcare Authority (Sonoma Valley, Palm Drive and Healdsburg hospitals), St. Joseph Health (Santa Rosa Memorial and Petaluma Valley hospitals) and the Marin Healthcare District (Marin General Hospital).

After a series of monthly meetings to review past relationships, the Regional Access Plan process settled into a quarterly calendar that rotated from facility to facility. The primary focus of these meetings over the next year was to develop a strategy that would enhance physician involvement and create a larger unified physician group. The Marin IPA played a key role because of their willingness to expand into Sonoma County. As the discussions continued, the role of the Annadel Medical Group with Marin IPA became crucial to the overall concept. This relationship would be the basis for expansion into Santa Rosa and the larger market share needed to attract an insurance product. Without this level of collaboration between the two physician groups, the Regional Access Plan process would probably have come to a halt.

The newly renamed Marin/Sonoma IPA was subsequently introduced into our communities via news stories and paid ads. While its significance to those of us developing the alignment was obvious and exciting, I am not sure its relevance to the rest of the community was apparent. For the first time in a decade, we had physicians in both counties working together in a unified group that still spoke to their independent nature. This effort has since been transformed

Mr. Doss, former executive director of the Northern California Healthcare Authority and CEO of the Petaluma Health Care District, is an independent healthcare consultant who lives in Kenwood.

into the Meritage Medical Network, which was recently enhanced by the addition of physicians from Napa County.

With the physician group in place, what we needed now was an insurance carrier who could understand our vision and situation. The insurance providers of the past were for the most part unable or unwilling to develop an alternative to what was already on the table. We needed a product that would engage with the broker community and create some excitement about what was possible.

Bill Hawn, of the North Sonoma County Healthcare District, and Richard Loos, of Richard Loos Associates, played a major role in identifying Western Health Advantage (WHA) as an insurance product that was founded and supported by physician groups and health systems. Through their efforts, we were able to make a connection with Garry Maisel, CEO of WHA. He quickly understood the alignments that we were making because he had developed the very same types of alignments along the I-80 corridor with multiple physician groups and health systems.

Garry made a presentation at a Regional Access Plan meeting at Santa Rosa Memorial Hospital in July 2011. His enthusiasm and confidence in WHA and the alignments between the physicians and health facilities were compelling. His presentation initiated a process of conversation and ultimately negotiation that created the North Bay Area Region of WHA.

WHA is a not-for-profit health plan founded in Sacramento and Solano counties. From the beginning, it has followed the model of physician and hospital collaboration. It has provided a much-needed alternative to the Kaiser/Sutter model in that area and has been price competitive.

WHA has already opened its North Bay Region offices in the same office complex as Meritage Medical Network in Novato. They have hired staff to meet directly with physicians' offices and to begin marketing their product in Marin, Sonoma and Napa counties. With the addition of more than 700 Meritage physicians, WHA now has 2,800 primary and specialty care physicians in Northern California. The health plan has the experience and background to develop their product along the 101 corridor.

Two key developments of this process are the continued emergence of Marin General Hospital and Santa Rosa Memorial Hospital in strong leadership roles for the North Bay Region. They are the principal partners with WHA and carry much of the credit for making this process possible. Marin General will work closely with Palm Drive and Sonoma Valley hospitals, and Santa Rosa Memorial will be aligned with Petaluma Valley and Healdsburg hospitals. WHA's health plans are capitated and require risk in the business process. Having two strong and active partners such as Marin General and Santa Rosa Memorial is essential to their success.

WHA will emphasize local healthcare delivery and an acute interest in each of the communities it serves. It will have within its physician directory local independent physicians who are working together to create a model for the upcoming health reform without having to sacrifice their community base.

The broker rollout meetings have already begun, and the initial reaction has been positive. The challenge will be to get employers to consider an alternative product. In the past, brokers were not able to provide employers with a product that was competitive in price. That is about to change.

I believe it is important and necessary to have community-based healthcare in Sonoma County. With WHA and its alignment with Meritage Medical Network and the seven local hospitals of Marin, Sonoma and Napa counties, we will have an opportunity to reverse a trend of healthcare being directed by corporate offices in out-of-area locations. Perhaps we can care for our own communities instead of being a minor participant in a corporate strategy.

This effort will only succeed if we have learned the lessons of the failure of Health Plan of the Redwoods in 2002. All participants must work together, and the physicians, hospitals and other providers within the network need to understand the importance of this integration.

As we move toward 2014 and greater implementation of the Affordable Care Act, including accountable care organizations, we will see if there is enough room for all in our new and evolving delivery system. I believe that the WHA plan and process may be the last chance for those of us who support an independent community model. ◇

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Improving STEMI Care in Sonoma and Mendocino Counties

Patrick Coleman, MD, FACC

In the event of a heart attack, even the smallest increment of time can drastically—often tragically—change a patient's prognosis. When a patient presents with an ST segment elevation myocardial infarction (STEMI), rapid intervention is necessary for the victim to have the best chance of survival.

The early 2000s marked the beginning of a revolution in STEMI treatment. Prior to this, cardiologists had used clot-dissolving drugs to open the occluded artery. Unsurprisingly, these drugs were effective only about 60% of the time, and they often had significant bleeding complications. Cardiologists looked to a growing body of research demonstrating the effectiveness of emergent intervention in the treatment of STEMI patients, using stents and balloons to disrupt the thrombus and reestablish blood flow in the coronary artery.

The urgency of any heart attack requires that all caregivers involved—paramedics, firefighters, triage nurses, ER physicians, and cardiologists—understand the time-sensitive nature of the situation and perform precise tasks with efficient command and expertise.

Dr. Coleman, a cardiologist at Northern California Medical Associates, directs the cardiac catheterization labs at Santa Rosa Memorial Hospital and Sutter Santa Rosa Medical Center.

Over the last seven years, cardiologists at Northern California Medical Associates joined with Sonoma and Mendocino EMS and local hospitals to start the Coastal Valleys STEMI Program. We have been assisted in this effort by many other local cardiologists who provide services in our cardiac catheterization labs.

The Coastal Valleys program is modeled on pilot projects from North Carolina and Minnesota. We have now established a protocol-driven treatment plan for any STEMI-related emergency call that occurs in Sonoma or Mendocino counties. Today, STEMI care in this two-county region is as good as anywhere in the country.

When a patient with heart attack symptoms calls 911, EMS paramedics arrive on scene and perform an EKG to look for ST elevation, the primary indicator of a STEMI. It is imperative to get the EKG results as soon as possible because test results positive for ST elevation initiate the lifesaving protocol. In order to expedite the STEMI response, the paramedics interpret the results themselves immediately after arriving on scene. We are still working to improve upon this step in the process. While all ambulances are equipped to perform EKGs, rapidly changing digital technology makes it extremely difficult to establish a reliable transmission between on-scene paramedics and hospitals. There simply isn't funding to keep pace.

Ideally, the paramedics would be able to transmit the EKG results to the STEMI receiving center, where an ER physician or cardiologist could confirm the STEMI from a distance. Having a confirmed diagnosis before the patient arrives would give the receiving center a tremendous head start in their preparations. Until the transmission technology evolves, however, paramedics will continue to interpret the EKG. If the paramedics determine that the results indicate a STEMI, they call ahead to a STEMI receiving center, where staff begins preparing the catheterization lab and an ER physician waits at the ready to confirm the EKG results.

There are two fully functioning cardiac cath labs in Sonoma County, one at Sutter Medical Center of Santa Rosa and the other at Santa Rosa Memorial Hospital. Both hospitals have been designated by EMS as STEMI receiving centers. Similar to trauma, patients are taken to one of the receiving centers based on geographic location of the call, disregarding patient preference or insurance factors. If the patient arrives at another hospital, an ER physician at that facility makes the diagnosis from EKG results and then notifies the nearest STEMI receiving center.

The protocol is designed so that, whatever happens, the STEMI receiving center prepares for the arriving patient while he or she is still in transfer. Once a STEMI diagnosis is confirmed, the on-call cath lab crew and cardiologist are notified, day or night, and the protocol

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becomes a race against time. The first person to arrive in the cath lab turns on and warms up the x-ray equipment. Then other crew members organize the procedural equipment specific to coronary intervention. Finally, the cardiologist and the remaining personnel head to the ER to interview and transport the patient.

The moment the STEMI patient arrives at the hospital until the first device crosses the occlusion is called "door-to-device" time. The current acceptable door-to-device time is 90 minutes, meaning we have just 90 minutes to open the patient's clogged artery to achieve the best outcome. This is why it's vital that a STEMI patient goes directly to a medical facility that has a cath lab for his or her treatment. The clock is ticking!

At both Sonoma County STEMI receiving centers, we average a door-to-device time of approximately 66 minutes. The program has been so successful that it's not uncommon for STEMI patients who arrive at other local hospitals to have a stent implanted within the next 90 minutes. Committees at both Memorial Hospital and Sutter Medical Center review each STEMI patient on a monthly basis to look for successes and opportunities for improvement.

The Coastal Valleys program has instilled a pervasive sense of urgency in people involved in all parts of the STEMI response protocol, and our efforts are paying off. For as far as we've come, however, there's still plenty of work to do to increase STEMI response efficiency even further. These improvements will require continued cooperation and collaboration between community cardiologists, ER physicians, EMS and hospitals. We know what needs to happen for STEMI patients to have a good chance of survival, but the process is complicated. Only through unified planning and optimal utilization of local emergency facilities can we give patients their best odds. ◇

Email: pcoleman@sonic.net

Frog Hospice

Jessica Les, MD, MSc

Two pellets in the morning and that's it," Brian said.

I hunched down with my hands on my knees to be level with Bop's tank and looked at him square in his unflinching, glass-marble frog eyes. "Does he always float like that?" I asked Brian.

"Yep . . . well, a lot of the time."

"How will I know he's okay? He looks sort of worrisome, floating in the water like that."

"You can tap the tank." Brian tapped the tank to reassure me. "See, he'll dart around in the water."

Bop snapped from his trance and darted across the tank in a blur. His front webbed toes scuffled at the water's surface, and then he again settled into motionless floating, just as before, but now at the other end of the tank.

"Hi Bop," I said. His skin was smooth, with a black and brown pebbled pattern on a background of olive green.

"Ellen and I will be back in two weeks," Brian said. "Bop will be fine. He might even sing for you at night."

Bop was a 22-year-old aquatic frog gifted to Ellen by her childhood friend, Liz, at Ellen's seventh birthday. No one suspected that Bop would survive through Ellen's college education, travel with her to medical school, and then take the 2,612 mile trip from North Hampton, Massachusetts, to Santa Rosa, California, for Ellen's residency in family medicine, where she and I met. Her husband, Brian, was a newly minted pediatrician, and through their decade of dating, he had become Bop's official tank maintenance man.

Now it was November of our intern year, and Ellen and Brian were leaving for a much-needed vacation. They asked me to frog-sit Bop while they were away.

I was honored, and terrified. Bop was 22 years old. What if he died while I was taking care of him?

The next morning, Brian and Ellen dropped Bop off at my apartment. The first few days went smoothly, and I felt less unnerved by Bop's listless floating.

My family and medical school friends planned to convene in a rented house in nearby Guerneville, along the Russian River, for Thanksgiving weekend. I would be away from my Santa Rosa apartment for three days, so I prepared Bop to make the journey with me. I carefully lifted his plastic tank with the neon pink lid into his makeshift carrier, a large lidless Tupperware box padded with old kitchen towels surrounding his tank, as Ellen and Brian had instructed, to make him secure for the car ride. I buckled the whole contraption in the front seat to prevent any sliding. Then I drove the winding road to Guerneville slowly, pair after pair of car headlights stacking up behind me as I delayed the holiday traffic.

I found the rental house, tucked off a small road near the river, and crept up the gravel driveway to minimize shimmying. Even so, the water in Bop's tank sloshed as if in an earthquake. I abandoned the wine, cheese and board games in the car to deliver Bop safely indoors. Everyone was awaiting his arrival.

"Oh, I didn't know he'd be so cute. His webbed feet are so delicate."

"How do you know he's alive?"

"What's the story of this frog again?"

Bop spent Thanksgiving with us. Although he never sang, various guests took turns feeding him each morning and intermittently tapping on his tank to make sure he was still alive. The more time we spent with Bop, the more curious we grew. We did some research on Wikipedia and learned he was an African dwarf frog. These aquatic frogs originated in shallow Congolese rivers where they hung close to the bottom, safe from predators, but would surface for air since they have lungs, not gills, for respiration. Apparently they were introduced to pet stores worldwide starting in the 1960s. Wikipedia stated they can live, in rare cases, up to 20 years.

Bop was living on borrowed time.

Dr. Les, a family physician, serves on the SCMA Editorial Board.

An African dwarf frog (not Bop).

One week later, I surrendered Bop with a sigh of relief to Brian and Ellen upon their return. Bop had survived my care.

Six months later, Ellen's second vacation of intern year arrived. I knew what was coming: frog-sitting. Brian delivered Bop to me in his Tupperware carrying case, and I unpacked his tank into his usual spot on a built-in shelf in my living room.

I am a dog person, but I grew to love Bop. I greeted his little amphibian presence each morning, and I looked forward to coming home from work to see him. He was a curious little frog. What did he think about all day? When he was floating, was he asleep? What was the secret to his longevity? Probably, lots of love and no predators.

Two weeks passed, and I sadly returned Bop into the care of his parents. For the following weeks I looked to the empty spot on the built-in living room shelf and thought, well, there's always Ellen's next vacation.

August rolled around, and Ellen and Brian were headed back East to visit old friends and family. I was on call in the hospital the night before their departure, so instead of the usual handoff, they left me a key to their house so I could fetch Bop from their living room on my way home from the hospital in the morning.

"Hi, Bop!" I said as I opened their front door. "I'm here to pick you up!"

My stomach twisted when I saw Bop. I am no frog doctor, but Bop didn't look right. I tapped the tank, and he did not dart.

"Oh, dear," I told him. "Let's get you to my house." I felt slightly reassured when I saw him scooting through the water in the tumult of walking his tank to my car. I drove him to my apartment and set him up in his usual spot. Bop still wasn't right.

I waited until the next morning, but when I reassessed Bop, he demonstrated no improvement. I called Ellen and Brian in Massachusetts. Like a worried teen babysitter of a fussy toddler, I described Bop's behavior to his parents and asked, "What should I do?"

We talked about changing his food. We discussed the risks and benefits of me trying to clean his tank. Eventually, we agreed on the following plan: partial water swap. Set out a bowl of tap water overnight to let it dechlorinate and equilibrate to room temperature. Then scoop out half his water and add in the fresh water without handling Bop, a risky endeavor, as Brian explained.

I executed the partial water swap, and it seemed to work. Bop perked up a little bit, not to his baseline, but still an improvement. I felt less uneasy. A few days later, however, Bop no longer darted through the water when I tapped his tank, so I prepared to repeat the water swap. I set out a large bowl overnight.

The next day I slept through my alarm and dashed off to work, neglecting to repeat a second water swap.

The next 36 hours did not go well. I received a scathing review of a book I had written the previous year. Unfortunately, I opened the email containing the review prior to rounding on my ICU patients, and it chewed on

me all day. That night, I came home to a threatening hospital bill for a supposedly pre-approved MRI of my hip, along with a jury duty summons. I dragged myself to bed saying, "Good night, Bop," already halfway to my bedroom.

The next morning Bop was chipper, making a second water swap seem unnecessary. He briefly fluttered about when I opened the flap of his tank and deposited two food pellets. I snapped the lid shut and tried to pull myself together for another day at work. I briefly studied Bop's feet. The webs were nearly transparent and folded up like a Spanish fan when he rested his front feet on the inside wall of the tank, his head half submerged and half exposed, his back legs floating freely. This seemed to be his preferred position.

"Bop, you are the best frog ever."

I left my apartment and headed to the hospital. I took care of hospital patients in the morning and then held my own clinic in the afternoon. It was a doozy. One of my clinic patients was so frail and ill that I sent her across the street to the emergency room to be evaluated for admission to the hospital. When I called over to give the medicine team a heads-up, they responded, "Oh you, mean Ms. Olivera?"

"What? Is she there too?"

"Well, she is the second patient of yours we admitted this afternoon."

"Well, I guess this will be the third," I sighed.

Five minutes later, labor and delivery paged me. One of my pregnant patients had arrived and was being evaluated for pre-term labor. That made four. I left clinic about 8 p.m., after two hours of charting, feeling like a bad doctor and utterly defeated. I was relieved to reach my back door. I dug through my work bag, full of papers and to-do lists for myself, eventually found my house keys, and unlocked my apartment door.

"Hi Bop." I said in a ragged voice. I let my work bag clunk down on the kitchen floor and slung my jacket on the back of a chair. I haphazardly sorted through my mail as I walked toward Bop's tank. I paid so little attention to my walking, I smacked my knee against the corner of the sofa. Satisfied that there was nothing as threatening as a $3,200 hospital bill or a jury duty summons in the mail today, I tossed the pile on the sofa and cast my attention to Bop.

He was floating upside down.

I witnessed about a dozen deaths during my intern year. I spent a lot of time thinking about death because people tended to wait to die until I was on call. I pondered what I perceived to be good deaths. Bad deaths. I considered a career in palliative care and hospice. I grew to realize the positive impact a physician can have on a patient and her family at the end of life. I viewed palliative care as a refreshing shift away from fighting against a disease and instead learning how to help patients and their families find creative ways to live with a disease, in whatever way suited them. I also witnessed that for some patients, giving permission to stop fighting and let go was the greatest gift. After a lot of personal toil, I made peace with those deaths.

But tonight I was pissed off at death. Really? Now?

A flood of tears came forth. I felt I had failed Bop, and Ellen and Brian too.

I plodded back through the past week since I had picked up Bop, looking for missteps. Would he have lived long enough for Ellen and Brian to arrive home had I swapped out the water a second time as I intended? Had the water been too cold? The weather had been unusually chilly that summer. Had I made some other mistake I wasn't aware of? Then I remembered this morning. I had told Bop he was the best frog ever. And he was.

That's when it hit me. I realized I had stepped back into the self-set trap that doctors often trigger when caring for patients at the end of life. We hustle through each day diagnosing and treating and thinking that our treatments will stave off death in our patients. Sure, some treatments we recommend are life-prolonging. But we are mistaken to think that if we provide all the correct medical care we can somehow cheat death, and that whenever a patient dies, it is a personal and professional failure, rather than a natural part of life.

Bop was 23 years old. This was probably 124 in human years. I had no hand in Bop's death. I had become his California frog-sitter, he my friend. And unknowingly, I had given him a place to die.

I had buried many small pets as a child, but Bop was not mine to bury. I consulted Kamin, one of my co-residents, on what I should do with Bop, post-mortem. Through tears, I followed Kamin's instructions. I gently lifted Bop out of his tank. This was the first time I had ever touched him. His body was stiff, but his skin was rubbery. I double bagged him in Ziploc and put him to temporary rest in the freezer until he could have a proper burial when Ellen and Brian returned home. I stood and looked at Bop in the plastic bags for a long, cold minute before I could bring myself to close the freezer door.

It was very late on the East Coast, so I waited until morning to contact Ellen and Brian.

Ellen was gracious. She said Bop lived a long life and he had to die sometime. She was just sorry that it happened while I was caring for him. Two days later Ellen called me back and said that something funny had happened. She was visiting her childhood friend Liz and suddenly realized that it was she who gave her Bop all those years ago on her seventh birthday. The two of them reminisced about the party, their childhood together and Bop's life woven into all those 23 years. Ellen said she probably wouldn't have had that conversation had Bop not just died and had she not been on the East Coast visiting Liz in person when it happened.

"Thanks for running the frog hospice for Bop," Ellen said.

I guess that's what I was doing but didn't know it.

"You're welcome." I said, and meant it. ◇

Email: jessicatekla@gmail.com

The Smiling Triathlete

Colleen Foy Sterling, MD

Dr. Marshall flexing his muscles.
Photo by Dr. Sterling.

When Bill Marshall was a boy growing up in the tiny town of Benzonia, Michigan, his grandmother took a look at his hands and predicted, "You'll either be a pianist or a surgeon!" She was right. He did become a specialist in obstetrics and gynecology, and as such, a surgeon—but I don't think that Grandmother Myrtle, who lived to be 103 years old, could ever have predicted that one day her grandson would become a world-class triathlete.

Twenty years ago, when Dr. Marshall was one of my attending OB/GYNs at the Santa Rosa Family Medicine Residency, I never guessed that we were in the presence of such an athlete. Little did we know that his calm and bemused style only hinted at the fitness habits he was cultivating outside the office. He is one of those affable folks who seem to have a special spring in their step and a constant little smile of amusement and contentment. Apparently, this is what can happen if you exercise every day in two or more sports!

Dr. Foy Sterling is a retired family physician who trained in the Santa Rosa Family Medicine Residency.

Work in medicine can be physically and emotionally draining. How does someone in medicine work diligently (and in solo practice, no less) for over 30 years and keep a *joie de vivre* that endures from pre-medical training through retirement? In Bill Marshall's case, his accomplishment has quite a bit to do with his habit of biking, running and swimming—a lot—every day of the week.

Bill grew up with lots of opportunities and a passion for sports, especially football—he was quarterback and captain of his high school football team. He also enjoyed basketball and track, where he broke the school records for both the 220- and 440-yard dash. He continued track for a year in college at the Ferris Institute (now Ferris State University) in nearby Big Rapids, Michigan. There is a smile in his voice as he quips, "Then I got married and that . . . changed everything."

Bill, now married to Sharon, slowed down on sports as he proceeded through college, medical school at the University of Michigan, four years in the Army, and an OB/GYN residency at UC Irvine. "In 1975, we moved to Santa Rosa and I started running again," he recalls. "I always considered myself a bit of a runner, and I started doing a lot of 10Ks. And then my wife and I started playing soccer in 1976. We played on co-rec teams. I trained to be a referee, played on a men's team, and started coaching. My wife was doing the same. She studied athletic training at Sonoma State (one of the first women to do so) and then was recruited to Santa Rosa High School in 1982, where she started a program to introduce young people to athletic training." She also worked at Santa Rosa Sports Medicine from 1985 to 1992.

Meanwhile, Bill had opened his solo practice and was delivering babies and performing surgery at Warrack Hospital, Community Hospital (where he also taught family medicine residents) and Memorial Hospital, even as Sharon was riding her bike from Rincon Valley to Sonoma State almost every day. She happened to meet a guy who was training for triathlons. "I think she did her first triathlon at Spring Lake in 1985," says Bill, laughing, "and of course she

won first place in her age group!" In fact, Sharon won gold in every triathlon she entered, but her triathlon career ended after she injured her knee in a ski accident. Undaunted, she took up dressage.

A little friendly competition got Bill started. He began paying attention to his own triathlete preparation and would train whenever he could: noon swims at the Montecito Health Club, running or biking after the office. Soccer started to fade out of Sharon and Bill's lives. "Once I started doing triathlons," he says, "we went from 20 years in soccer, dropped it all, and moved on to triathlons."

Being a triathlete has changed Bill's life. In some ways, he loves the training more than the competition. "I took a special master's swimming program at Stanford," he recalls. He participated in about a dozen triathlons a year. He also took part in seven Iron Man competitions, which consist of a 2.4 mile swim, 112 mile bike ride and 26.2 mile run. "My wife watched this," says Bill, "and she observed that if I wanted to participate in triathlons for a long time she recommended Olympic distances: 1,500 meter swim, 40 kilometer bike ride and a 10 kilometer run. I began to cut back to six to eight events a year, but I continued training all year long. April though October is my 'competitive season.' I slack off a bit after December, but by February I start picking up the pace again. I keep on swimming almost every day and add a run or a bike."

And yes, Bill, now in his 70s, did test about 10 years younger than his chronological age on the RealAge Test. "My training has kept me in really good physical health," he adds humbly. "If I don't train on any given day I feel out of sorts and 'bloggy.' I guess you could say I am kind of addicted to training!"

Bill's current schedule includes swimming four days a week, running five days a week, and biking about two days a week. Five years ago he dropped five pounds intentionally and started training differently—at "race intensity." The new intensity meant that he would run, bike or swim as if he were in a race, with all the mental intensity to accompany the physical work.

Dr. Marshall in a rare moment of repose.
Photo by Dr. Sterling.

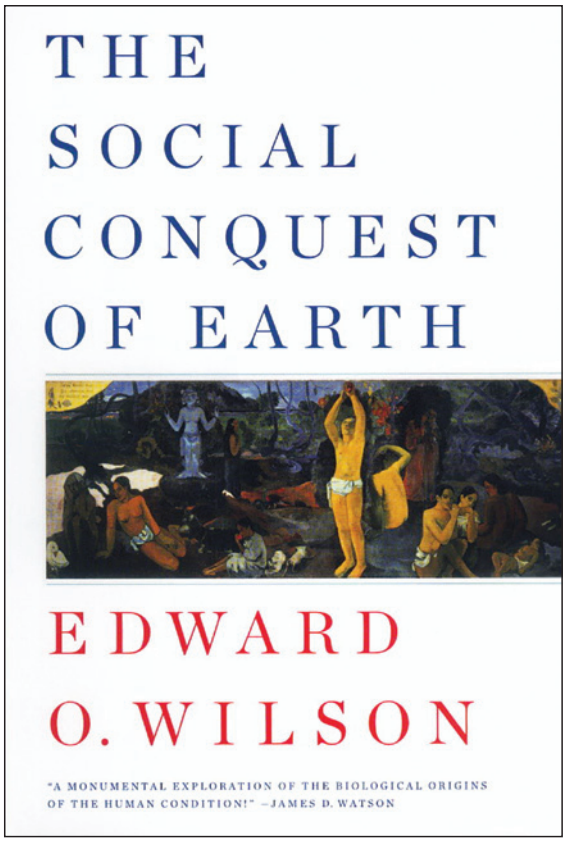
After his change in training intensity, Bill started doing quite well on the familiar "bronze, silver or gold" podium. "Currently there are three of us that go back and forth, taking turns being in first place," says Bill, as he rattles off his current record of a triathlon first place for his age group (70–75 years) in Hungary, second in China, third in New Zealand. In national competitions in the United States, Bill has taken first place in his age group once, and second place three times.

"It is very gratifying," reflects Bill, "and you really have this good feeling thinking that not many people can say they are the best in the world. But glory is fleeting. The race is over and it is on to the next, and you might not win the next time around." ◇

Email: foysterling@comcast.net

From Me To We

Brien Seeley, MD



The Social Conquest of Earth, by Edward O. Wilson, 352 pages, Liveright.

By nature, we are mainly joiners—joiners who recruit each other. Being recruited is innately flattering, and it marks the important transition from "me" to "we." One's first recruitment is likely to be memorable. For the egocentric 5-year-old, it could happen on a kindergarten playground when a playmate asks, "Wanna be my friend?" An invitation to belong can change one's life. My most momentous recruitment occurred in 1965, when Anne Powell asked me to the high school Turnabout Dance. I was so charmed that Anne and I just celebrated our 42nd year of marriage.

Recruiting abounds at many levels beyond the simple pairing up of couples or Facebook friends. People are recruited to join the Red Cross, the Muslim Brotherhood or the U.S. Marines. Joining any of those entails some level of obligation to their slogans, which range from "The greatest tragedy is indifference" to "Islam is the solution" to "The few, the proud, the Marines."

As we grow up, we learn that a group's values matter. In the late 1960s, as an impressionable high school jock, I was recruited to Cal to play football. "Go Bears" became my mantra. But sports rah-rah took a back seat in the '60s to Berkeley's radical political causes like Free Speech, People's Park and the Black Panthers. Naïve but intelligent and physically strong students in their late teens were being recruited left and right, but mostly left. My biochemistry professor disbanded our class during the mass anti-ROTC demonstrations, stating that his ethics compelled it, and that he would give an automatic "A" to any student submitting a midterm paper on "antidotes to tear gas." Groups of all kinds seemed to know intuitively that college kids, whose frontal cortex we now know does not fully mature until after age 25, were ripe for molding to their cause.

My freshman year, the Campus Crusade for Christ invited me to attend an initiation rite in a tiny vault-like room where two volunteers who declared themselves "brothers in Christ" asked me to hold hands and avow lifelong allegiance to their recruiting program. Months later, I was recruited by yet another group, but this time its cause was "honor among thieves."

The thieves belonged to a ragtag group of Irish immigrant groundskeepers at the huge cemetery where my summer job was cutting grass. Fergus and Danny, who had worked there for decades, shared a role like that of Fagin in *Oliver Twist,* serving as recruiters for the gang. One morning, the company foreman handed out brand new shovels and rakes to the groundskeepers. At quitting time, Danny hid his new tools near a hole in the south fence. When I asked Fergus why, he explained that this was so Danny could fetch them that night after work and take them home to keep. He quickly added, "You'll do well, lad, to say no more about it, just like the rest of us. By jeebers, God helps him who helps himself!" Fergus was presumably

Dr. Seeley, a Santa Rosa ophthalmologist, serves on the SCMA Editorial Board.

unaware that this self-righteous adage is not to be found in scripture. He might as well have sung, "You've got to pick a pocket or two."

Fergus and Danny's workplace culture had devolved into one of cheating, in which resentful employees deliberately made any task take as long as possible while looking busy every time the foreman drove by. Such a culture of selfish cheating is common and can rot any enterprise or bureaucracy. It lies on one end of the "me to we" spectrum whose opposite end is a culture of altruistic self-sacrifice.

The most naturally altruistic groups on earth are ant colonies, whose gene-driven, robot-like workers have enabled them to dominate the insect world for 50 million years.

Renowned biologist Edward O. Wilson is a world expert on ants. His new book, *The Social Conquest of Earth*, uses the altruism of ant colonies as an allegory for the human race. Wilson tells how microevolution, driven by social recruitment, rapidly built human brains with propensities for heritable group behaviors. He explains the role of those behaviors in the origin of civilizations and religions and why these findings have fateful implications for modern society. His book is a tour de force that will likely become his ultimate contribution to science and the triumph of his distinguished career.

Like the foundational scientific discoveries of Copernicus, Darwin and Freud, Wilson's expose changes how we think of ourselves and of our place in the cosmos, with insights that he hopes will launch a "new Enlightenment."

What enabled humans to become the supreme animals on Earth was not our upright posture, omnivorous diet or dexterous hands. Rather, claims Wilson, it was the evolution of our large, uniquely social brain and its instincts for recruiting others. Wilson defines a particular matrix of cooperation as "eusociality," an occurrence in nature wherein a species shares a genetically determined instinct to build defensible nests, live in multigenerational communities, practice division of labor and behave altruistically—just like ants. The evolution of such "me to we" collaboration was the single most important factor in empowering groups of Homo sapiens to survive predators like lions and tigers and outcompete other protohuman groups over millions of years. How it happened is controversial.

Wilson claims that the gene-driven brain changes necessary for eusociality began with the huge increase in neurons that coincided with our evolution from herbivorous tree dwellers to carnivorous hunters on the savannah. That increase in neurons, some biologists propose, may have been driven by the need for hunters to master accurate spear throwing. Indeed, the precision motor control that enables a major league pitcher to hit a 5-inch target from 60 feet away demands the near simultaneous firing of an enormous "chorus" of neurons. As those neurons were added to the brains of our forbears, they were gradually woven into neural modules for thinking, language, speech and social planning, claims Wilson. Those modules enabled the behaviors that are widely accepted as making us uniquely human.

Wilson's insights from paleontology add to the abundant modern evidence that one's brain determines who one is and that genes influence both reflexes and learned behaviors. The learned behaviors develop from pre-adaptations controlled by "epigenetic rules." These rules, he says, define human nature and enact adaptations evolved over millennia in response to both environmental selection pressures and culture. He cites as examples of human nature the nearly universal consistencies in human phobias, empathy, language, grammar, facial expressions and personality types found across the globe.

The human genome, says Wilson, is more than 80% comprised of developmental genes that when triggered by experience serve as switches to control other genes. Experiential triggers, both environmental and cultural, that switch on those developmental genes can elicit brain structural changes as well as subconscious behavioral tendencies. This, Wilson claims, is how genes and culture co-evolved to build the brain's socially adaptive subconscious processes. Our subconscious is thus a network determined by genes plus experience ("nature plus nurture") that sets our drives, learning tendencies and the boundaries of free will beyond what our consciousness can control or understand. Since youngsters do not control their own fate in terms of the genes and experience that mold their brains and behaviors, our attitudes toward culpability, punishment and society's collective responsibility for nurture need rethinking.

To be successful, groups throughout evolution have applied stern punishment to selfish or disloyal behavior. Ants will gang up on and kill any colony member so indicted, says Wilson. Human society is likewise vigilant to identify and punish cheaters, and it will often apply swift and unforgiving judgment to people who are even accused of certain hot-button crimes. Groups attempt to reinforce loyalty with pledge ceremonies, chants and battle cries. Both fraternities and gangs test their recruits' allegiance with hazing and initiation rites.

Years ago, my patient Mr. Hatfield sheepishly confided to me that what had finally ended the infamous feud between his ancestors, the Hatfields and McCoys, was a kind of group vigilance. The women of both clans cooperated to deprive any man who feuded from having any chance for sex. The vigilance of those women exemplified how group power can triumph.

According to Wilson, our naturally evolved, subconscious instincts for social justice might serve as the stone tablets for secular morality, since the spectrum of human kindliness evolved long before the emergence of religions. That spectrum extends from intense selfishness at one end to self-sacrificing altruism on the other. The mean of that spectrum has always defined a natural

consensus for fairness, and the tension between its extremes was ever crucial to the emergence of humans as the dominant species on earth. The spectrum, says Wilson, whose fundamental metric is simply the Golden Rule, could arguably comprehend all the other ranges of secular ethics, from love to hate, loyalty to betrayal, temperance to excess, courtesy to injustice, and courage to cowardice.

Wilson points out that the tension between selfish and altruistic individuals ensures hybrid vigor, while for groups it provides checks and balances, like the two-party system. This tension prevents the emergence of a vulnerable or tyrannical monoculture. America's recent election affirms that such tension continues today in both society and the minds of individuals. America has blue states versus red states, the 99% versus the 1%, and the Democrats' "We're all in this together" versus the GOP's "I've got mine."

Wilson uses science to challenge religion and bigotry. The enhanced pair bonding induced by oxytocin release during sexual intercourse, for example, produces a stabilizing societal benefit. That benefit, he argues, is reason enough to revoke the papal ban on contraception. The persistently high global prevalence of genes that induce homosexuality must indicate that it has some value to society, he says, since the population frequency of those genes is much higher than could be explained by random mutation rates, and because gays and lesbians generally do not produce offspring.

Group evolution raises new questions in the age of the Internet. Will Luddites who shun computers and refuse to acknowledge evolution, the Big Bang, or other modern scientific insights end up going extinct, like earlier branches of pre-human primates who never learned to adopt and share tools?

The Social Conquest of Earth is ironically an anti-war book. The startling parallels Wilson draws between human and ant colony behaviors become creepy when he describes the relentless and overwhelming group power of soldier ants. This reminds us that unrestrained corporate, nationalistic and fundamentalist agendas can be tyrannical. Such power enabled the Nazis to crush both foreign resistance and internal dissent. But there is a good side to group power: groups took down the Berlin Wall and launched the Arab Spring.

Wilson's most compelling message is that we must finally harness common decency to scientifically informed, self-aware group power for good. That good, says Wilson, will be to save the planet, its climate and all its biological diversity. ◇

Email: cafe400@sonic.net

NEW MEMBERS

Todd Antenucci, DO, Family Medicine*, 401 Bicentennial Way, Santa Rosa 95403, New York Med Coll 2009

Ali Sina Bari, MD, Plastic Surgery, 145 Foss Creek Cir., Healdsburg 95448, Stanford Univ 2006

Jose Chibras, MD, Internal Medicine, 1179 N. McDowell Blvd., Petaluma 94954, Michigan State Univ 1990

Rafael Fletes, MD, Nephrology, 2301 Circadian Way #A, Santa Rosa 95407, Univ Chicago 1991

Rachel Friedman, MD, Family Medicine, *Integrative Medicine,* 401 Bicentennial Way, Santa Rosa 95403, Yale Univ 2008

Eugene Hong, MD, Urology*, 401 Bicentennial Way, Santa Rosa 95403, New York Univ 1999

Tinh Hua, DO, Emergency Medicine*, Internal Medicine*, 401 Bicentennial Way, Santa Rosa 95403, Chicago Coll Osteo Med 2000

Marisha Lockwood-Chilcott, MD, Family Medicine*, 500 Doyle Park Dr. #G04, Santa Rosa 95405, UC Davis 2003

Helena Longin, MD, Dermatology, 3883 Airway Dr. #130., Santa Rosa 95403, Pennsylvania State Univ

Erin Lunde, MD, Family Medicine, 3569 Round Barn Cir., Santa Rosa 95403, Harvard Med Sch 2005

Jalet Ontanillas, MD, Internal Medicine, 3925 Old Redwood Hwy., Santa Rosa 95403, West Visayas State Univ 2000

Majonel Ontanillas, MD, Internal Medicine*, 401 Bicentennial Way, Santa Rosa 95403, Ceylon Institute Med 1992

Cathryn Ross, MD, Pediatrics*, 1144 Sonoma Ave. #113, Santa Rosa 95405, Harvard Med Sch 1972

Anish Shah, MD, Psychiatry, 1049 4th St. #G, Santa Rosa 95404, Sardar Patel Univ 1996

Lynn Silver-Chalfin, MD, Pediatrics*, Public Health & Preventive Medicine, 3313 Chanate Rd., Santa Rosa 95404, Johns Hopkins Univ 1983

Jean Talleyrand, MD, Family Medicine, 5202 Old Redwood Hwy., Santa Rosa 95403, Boston Univ 1995

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* = board certified
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Small suite for lease. 800 sf. Reception, business office, 3 rooms, Summerfield Rd. on Sutter/Warrack campus. Contact Connie, 707-525-0211.

Office space needed, Petaluma
Medical office space needed in Petaluma near Petaluma Valley Hospital for physician to see patients, no staff needed. Need one day a week, Monday or Thursday. Contact Tammy at 707-252-8407 or nvna@napanet.net.

Office space needed, Santa Rosa
Medical office space needed in Santa Rosa for physician to see women's health patients. Need one day a week. Contact Kristyn at 415-827-9945.

Roll on, Bob

Rick Flinders, MD

I first saw Willie Mays in 1958, when I was 12 years old. I watched him play for 14 years as a San Francisco Giant, through the prime of his career, the greatest baseball player I ever saw. Maybe Roberto Clemente had a better arm. Maybe Barry Bonds was a better hitter. But no one has ever played the game of baseball better than Willie Mays. He was magnificent.

In 1972, Willie was traded to the New York Mets. I watched him flail at the plate, no longer able to catch up with major league fastballs. In center field he was no longer graceful, even once dropping a ball while attempting his signature basket catch. It was painful to watch. He retired in 1973.

I first saw Bob Dylan in 1965, when I was 19 years old. I'd been struck between the eyes with songs like "Masters of War," "Chimes of Freedom," and "With God on Our Side." On stage at the Berkeley Community Theater in December 1965, he stood alone with only an acoustic guitar and harmonica, and he mesmerized us. After intermission, he returned with an electric Stratocaster and four musician friends he called "The Band." He concluded the show with a song he'd just released, "Like a Rolling Stone." He was magnificent.

In the past half-century, few artists have had more impact on our language and culture than Dylan. He changed popular music the way Einstein changed modern physics: he changed everything that followed. Dylan took the lyrics of popular music away from the hacks of Tin Pan Alley and placed them in the hands of poets. As Bruce Springsteen said of the influence of Dylan's music on his generation: "Elvis freed our bodies. Dylan freed our minds." A recent concordance of legal decisions in U.S courtrooms showed Dylan's words the most frequently cited lyrics in judicial opinions, from local magistrates to the Supreme Court.

Bob Dylan at the Presidential Medal awards ceremony in May 2012.

In the years since that first show in Berkeley, I've seen Dylan in concert 15 times, each performance as unpredictable as the performer himself, but always worth seeing.

Until now.

This October, at the Greek Theater in Berkeley, it was hard to watch Dylan on stage. Listening was even more painful. His band, still composed of world-class musicians, was only loud and lifeless. His voice, over-amplified to compensate for 50 years of vocal cord injury, echoed only harsh syllables from his former eloquence.

His most recent album had promised more. Called *Tempest,* the same title as Shakespeare's final play, it was rumored to be perhaps his final work. Two songs in particular provided proof that Dylan can still bring the poetry. The title track is a poetic vision of the night the *Titanic* sank, with lyrics sufficiently vivid to bring you to tears. Another song, "Roll on, John," is a touching tribute to his old friend John Lennon:

> Shine your light, move it on
> You burned so bright, roll on, John

Though the poet still lives, the voice is gone.

Bob Dylan has earned the right to sing forever. It's what he does. But, for the first and only time in 50 years, I walked out early from a Dylan concert, the last one I'll ever attend. How does it feel? Like watching Willie Mays about to drop a routine fly ball from a basket catch. And while it breaks my heart to say it, Bob, I say this with nothing but love and with gratitude for all you've given us. May you live long and continue to know and speak the truth as few others have. May your heart always be joyful and your song always be sung. But from that stage where you burned so bright and delivered a lifetime of magnificent lines and transcendent songs, it is time to roll on. ◇

Dr. Flinders, who serves on the SCMA Editorial Board, is a lifelong fan of Bob Dylan.

Email: flinder@sutterhealth.org

SCMA Awards Dinner

SCMA President Dr. Walt Mills emceed the event.

Awardees included (left to right) Dr. Jeff Haney, Dr. Mark Netherda, Dr. Mary Maddux-González, Dr. John Dervin, Dr. Catherine Dr. Gutfreund and Dr. Sanjay Dhar. Joining them is Dr. Mills (far right).

Dr. Rick Flinders (left) presented the Lifetime Achievement award to Dr. John Dervin.

Dr. Dervin was honored for his work with the Santa Rosa Family Medicine Residency.

Dr. Jeff Haney (left) received the Outstanding Contribution to the Community award from Ritch Addison, PhD. Inset: Dr. Haney's award plaque.

Dr. Mary Maddux-González presented the Outstanding Contribution to Sonoma County Medicine award to Dr. Mark Netherda.

Dr. Lynn Mortensen (left) presented the Outstanding Contribution to SCMA award to Dr. Catherine Gutfreund.

Dr. Sanjay Dhar (left) received the Article of the Year award from Dr. Stephen Halpern.

Dr. Mills presented the Recognition of Achievement award to the Redwood Community Health Coalition, represented by (left to right) Dr. Mary Maddux-González, Naomi Fuchs and Dr. Danielle Oryn.

Dr. Mills and his wife, Elizabeth.

Dr. David Staples and his wife, Charlene.

Barbara Ramsey, of the SCMA Alliance and Foundation.

SCMA Executive Director Cynthia Melody (right) and her daughter, Erika Goodwin.

Each table included a handmade centerpiece.

Attendees enjoyed a leisurely dinner before the awards presentations.

The evening included several standing ovations for award recipients.

An overflow crowd of more than 100 physicians, spouses, significant others and guests attended the annual SCMA Awards Dinner on Dec. 6 at the Vintners Inn in Santa Rosa. The evening began with a lively social hour, followed by dinner and awards presentations to five local physicians and the Redwood Community Health Coalition. The presentations were made by longtime colleagues of the awardees, and the stories they told were by turns amusing and inspiring. Every awardee received a standing ovation. The event was cosponsored by NorCal Mutual Insurance Company.

These photos and more, all by Will Bucquoy, have been posted on Flickr at www.flickr.com/photos/91183744@N07/.

HOD 2012

CMA delegates set policy at annual meeting

More than 700 California physicians convened in Sacramento October 13-15 for the 2012 House of Delegates (HOD), the annual meeting of the California Medical Association (CMA). Each year, physicians from all 53 California counties, representing all modes of practice, meet to discuss issues related to health care policy, medicine and patient care and to elect CMA officers.

by Elizabeth Zima and James Noonan

Over 120 resolutions were introduced and debated in reference committees on Saturday, October 13, 2012. Over the next two days, the complete house met again to debate and vote on reference committee recommendations. A total of 97 resolutions were adopted.

The debates were passionate, polite and sometimes humorous. For example, during a debate on the health hazards of sitting, one speaker suggested that the House stand for the rest of the debate. In another instance, during a contentious debate on whether to support nurse practitioners' ability to sign POLST forms, the debate was interrupted so that former CALPAC chair, and newly elected CMA president-elect Richard E. Thorp, M.D., could have his mustache shaved off by his wife – part of a fund-raising challenge.

On Sunday the House elected new officers, including Sacramento pediatrician, Paul R. Phinney, M.D., as the 2012-2013 CMA President, and the now clean shaven Dr. Thorp as president-elect. The rest of the CMA Executive Committee were affirmed by the HOD, including the immediate past-president, James T. Hay, M.D., speaker, Luther F. Cobb, M.D., vice-speaker, Theodore M. Mazer, M.D., board chair, Steven E. Larson, M.D., and board vice-chair, David H. Aizuss, M.D.

The following are summaries of some of the resolutions that were adopted as policy.

House of Delegates 2012

Revised blood donor deferral criteria

(Resolution 108-12)

The delegates expressed support for the use of rational, scientifically-based deferral periods for blood donations, applied based on level of risk rather than on sexual orientation.

Awareness and prevention of bullying

(Resolution 113-12)

The delegates called on CMA to support awareness and prevention of bullying in all its forms and to support the development of family, school and community programs and referral services for victims and perpetrators of bullying.

AB 32 and California's clean air leadership

(Resolution 117-12)

The delegates voted that CMA should support implementation of the California Global Warming Solutions Act of 2006, which protects the health of Californians from climate change.

Safer furniture flammability standards

(Resolution 125-12)

The delegates asked that CMA endorse a revision of the California TB 117 furniture flammability standards, which would not require harmful flame retardants yet provide more effective fire safety using barrier technology and flame resistant fabric covers.

Support for amending the affordable care act

(Resolution 201-12)

The delegates directed CMA to support amending the Affordable Care Act to address issues of concern to the practice of medicine.

Duel eligible monitoring and reporting

(Resolution 208-12)

This resolution directs CMA to collect data from its membership regarding difficulties with the planned transition of dual eligibles to managed care plans and to report the findings to the California Department of Health Care Services, the California Department of Managed Health Care and the federal Centers for Medicare & Medicaid Services.

Electronic prescribing and EHR payment reductions

(Resolution 214-12)

The delegates voted to oppose financial penalties by any payor for physicians who do not adopt health information technology, such as electronic medical records and electronic prescribing.

Health care equality for same-sex household members

(Resolution 505-12)

The delegates voted to recognize that denying civil marriage contributes to poorer health outcomes for gay and lesbian individuals, couples and their families. The resolution also calls on CMA to support measures providing same-sex households with the same rights and privileges to health care, health insurance and survivor benefits afforded to opposite sex households.

Pharmacist's substitution of physician prescriptions

(Resolution 507-12)

The delegates asked that CMA consider legislation to make it illegal for pharmacists to receive financial incentives to substitute a physician's prescription.

Increasing utilization of POLST orders

(Resolution 512-12)

The delegates approved a resolution that calls on CMA to support awareness and use of Physicians Orders for Life-Sustaining Treatment (POLST) forms by physicians in all appropriate instances where medical services are provided to patients at the end of life.

HIPAA and medical record accessibility

(Resolution 606-12)

The delegates asked CMA support a study on the extent to which HIPAA laws impede the timely transfer of medical information necessary for the appropriate coordination of care.

Helping physicians improve their health

(Resolution 610-12)

The delegates voted to encourage all physicians and physicians-in-training to properly manage their own physical and mental health and to serve as exemplars of healthy behaviors.

The complete and final actions of the 2012 House of Delegates are available to members at www.cmanet.org/hod under "Documents."

Sacramento pediatrician elected CMA president

Sacramento physician Paul R. Phinney, M.D., was installed as the 145th president of the California Medical Association (CMA) during the organization's annual House of Delegates held in Sacramento October 13-15.

Dr. Phinney is a pediatrician at Kaiser Permanente and has been a member of CMA since 1988. He has served in a number of leadership roles, including president-elect, chair of the CMA Board of Trustees and previously served on the CMA Council on Legislation and on the CMA Political Action Committee (CALPAC) Board of Directors.

Addressing the group of nearly 1,000 physicians, residents, medical students and others on Sunday, Dr. Phinney challenged his colleagues to lead change rather than succumb to the "default future."

"We owe it to the public and to our profession to be leaders in health care reform – to create a better future that we help invent," he said to the crowd.

"We live in turbulent and uncertain times that very likely will produce the most rapid change in the delivery of health care that the nation has seen in decades, and I look forward to tackling those challenges head on in my term as president," concluded Dr. Phinney.

Speaking to his goals for the next year, Dr. Phinney acknowledged the next generation of students entering medicine. "Mentorship deserves our attention, and will be an area of my focus over the next year. A healthy future requires up-front investment," he said.

Dr. Phinney's complete address to the delegates can be watched on CMA's YouTube channel, www.youtube.com/cmaphysicians.

Also serving on CMA's 2012-2013 Executive Committee are:

- Immediate Past President James T. Hay, M.D., a San Diego family physician
- President-Elect Richard E. Thorp, M.D., an internal medicine physician in Paradise
- Speaker of the House Luther F. Cobb, M.D., a surgeon in Humboldt County
- Vice Speaker of the House Theodore M. Mazer, M.D., a San Diego ear, nose and throat specialist
- Chair of the Board of Trustees, Steven E. Larson, M.D., an internist and infectious diseases consultant in Riverside County
- Vice Chair of the Board of Trustees, David H. Aizuss, M.D., a Los Angeles ophthalmologist

CMA says denial of civil marriage to same sex couples has negative health impact

On Sunday, October 14, 2012, the California Medical Association (CMA) House of Delegates passed a resolution calling for health care equality for same sex households. Hundreds of physician representatives from across the state voted to support a resolution that states "denying civil marriage contributes to poorer health outcomes for gay and lesbian individuals, couples and their families."

In written testimony, the sponsors of the measure, the CMA Residents and Fellows Section, said, "legal protections afforded to same-sex couples are crucial given that marriage is a strong predictor of health insurance in the U.S. In particular, women in same-sex households tend to have less health insurance than woman in opposite-sex households.

"As a consequence, children in same-sex households lack the protections of health insurance afforded by marriage," the document continues. "Having health insurance does not provide same-sex couples with the financial and legal protections that married couples receive. Same-sex couples are not covered by the protections of COBRA or the Family and Medical Leave Act. Same sex couples are also not typically recognized as family by blood or marriage and are denied the right to make surrogate health care decisions for their loved ones."

The resolution **(505-12)** would also require CMA to work to reduce health care disparities among members of same-sex households, including minor children. It also calls on CMA to support measures providing same-sex households with the same rights and privileges to health care, health insurance and survivor benefits afforded by opposite-sex households.

CMA delegates call for increased advocacy on duals transition

Recognizing the challenges that California's planned shift of Medicare and Medi-Cal dual eligible patients to managed care plans will pose to patients and the physicians that serve them, the California Medical Association (CMA) has adopted policy to help keep physician concerns in clear view of the agencies orchestrating the transition.

The policy **(Resolution 208-12)**, which was adopted at the CMA's annual House of Delegates meeting, calls on the association to collect data from its membership regarding difficulties with the planned duals transition and, if difficulties are found to be widespread, report them to the California Department of Health Care Services, the California Department of Managed Health Care and the federal Centers for Medicare and Medicaid Services.

During the floor debate regarding the issue, delegates noted that the state's Coordinated Care Initiative, which includes a pilot program to passively enroll patients eligible for both Medicare and Medi-Cal in eight of California's largest counties, would see more than 75 percent of the state's dual eligibles transitioned to managed care plans. The shift, speakers said, would likely lead to considerable confusion among patients and almost certainly interrupt relationships that have been established with their existing physicians.

Under the pilot program, patients will be enrolled in a managed care plan unless they actively opt out.

In addition to asking that CMA monitor the transition, the newly adopted policy also requests that the association advocate that the appropriate state agencies provide "full and clear disclosure" on options and consequences facing patients affected by the pilot program.

More information regarding the dual eligible transition can be found in CMA's online duals resource center, at www.cmanet.org/duals.

Delegates strongly oppose Medicare RAC audits

Members of the California Medical Association's (CMA) House of Delegates spoke out strongly against aggressive down-coding efforts being taken up by Medicare's Recovery Audit Contractor (RAC) firm, and have adopted policy that officially puts the association on record as opposing the practice.

The resolution, **222-12**, stems from an ongoing problem of an out-of-state auditing firm, Connolly Healthcare, selectively down-coding claims on behalf of Medicare, forcing physicians to undertake costly and time-consuming appeals.

The audits and subsequent down codes, which several speakers equated to financial "bounty hunting" on behalf of the Centers for Medicare & Medicaid Services (CMS), were almost always reversed upon physician appeal, which suggested that they were of little merit to begin with, speakers said.

"I can't tell you how outraged we doctors should be that this is going on," James Hinsdale, M.D., a past CMA president, said during the resolution's floor debate.

In addition to asking that CMA work to stop the audit practice, the resolution also requests that, if efforts to halt the practice are unsuccessful, CMA urge CMS to reimburse physicians who file successful appeals for the time and resources expended in the appeal efforts.

Successful passage of the resolution brought CMA in line with the American Medical Association's (AMA) position on the matter. AMA has been actively lobbying CMS to halt the recovery audits.

ACA topic of heated debate at House of Delegates

Since the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, it's been a virtual certainty that delegates at the annual House of Delegates meeting would debate to influence policy regarding the landmark reform bill.

This year's gathering was no exception, as resolutions touching upon various aspects of the ACA were introduced, and in some cases, adopted as official California Medical Association (CMA) policy.
Of the resolutions introduced and debated over the weekend, it appears that Resolution 202-12 will produce some of the most immediate results.

The resolution, which deals with the California Health Benefits Exchange, asks that CMA support several actions that will help ease the transition of roughly 1.6 million new enrollees to the state's Medi-Cal program, as well as a list of requirements that will help protect physicians when contracting with plans offered through the exchange's online marketplace.

Specifically, the resolution asks that county and state funding sources that currently help provide care for medically indigent adults follow those individuals when Medi-Cal is expanded in 2014, and that the exchange takes a more active role in monitoring network adequacy of its offered plans.

The issue of network adequacy has already garnered a significant amount of attention from CMA staff, but an agreeable solution has yet to be reached with exchange leadership.

A separate resolution, **201-12**, reaffirmed CMA's position of continuing to work toward amending the ACA to "address issues of concern to the practice of medicine," and was adopted by the House.

Finally, two resolutions, **204-12** and **205-12**, launched the seemingly annual debate over single payor coverage in California.

During the reference committee hearings, supporters and opponents of single payor in California took to the microphone to voice their opinions on the matter, providing some of the most passionate and ideologically divided debate of the weekend.

Ultimately, reference committee members recommended that delegates disapprove both resolutions, noting that CMA has "well thought out and longstanding" policy on the issue of single payor. (CMA's Policy Compendium is available to members at www.cmanet.org/policies. The new policies passed this year will be added to the compendium soon.)

For more information on any of these resolutions, or general reform activities in California, please subscribe to CMA's regular reform newsletter, *CMA Reform Essentials* at www.cmanet.org/reform-essentials.

CMA debates resolution that calls on insurers to cover e-mail consultations

As advances in technology continue to redefine health care, the California Medical Association (CMA) is taking steps to bring the physician-patient relationship into the 21st century.

During the association's annual House of Delegates meeting, a resolution was introduced that would ask CMA to support legislation requiring insurance providers in California to include "telephone or other electronic patient management services" in their covered services, while also allowing physicians to bill patients directly for the provision of such services.

Currently, insurance providers are not required to cover consultations that occur via telephone or email, and physicians in most instances have no legal way of billing patients or payers for such services.

Throughout a lengthy period of floor debate, several

CALPAC fundraising record shattered at House of Delegates

CALPAC, CMA's political action committee, carried two things into the 2012 House of Delegates meeting – last year's three-day fundraising record of $110,000 and a fully mustachioed chair posing a challenge to delegates in attendance.

In the end, neither would emerge from the weekend unscathed.

In a record-setting show of support for CALPAC, CMA members contributed a total of roughly $152,000, besting last year's mark while also exceeding the $150,000 goal established before the House of Delegates.

Throughout the weekend, attendees were informed that, should the goal be met, outgoing CALPAC Chair and new CMA President-Elect Richard Thorp, M.D., would shave his moustache during the full house session held on Monday morning.

With the final tally confirmed, Dr. Thorp took to the stage to have his upper lip shorn clean by his wife, Vicki. (Check out the photos on CMA's facebook page, www.facebook.com/cmaphysicians.)

While the record breaking weekend was a House-wide effort, several counties, including San Diego, San Francisco and Santa Clara, were recognized for their outstanding participation.

The donations collected over the weekend, as well as all contributions made to CALPAC, will be used to support candidates who share medicine's agenda and priorities and will work to affect policies beneficial to the House of Medicine.

speakers noted that patients are becoming increasingly reliant upon remote interaction with their physicians, while insurers only cover services offered in a face-to-face setting, with few exceptions. If this does not change, speakers noted, physicians would be facing considerable financial losses as the trend toward remote interaction continues.

While support for the concept of requiring insurers to pay for telephone and email consults was nearly unanimous, the specific language of the resolution drew input from across the House, leading to nearly an hour of open discussion of the issue.

Ultimately, recognizing the importance of the matter and the limited time available for debate, delegates opted to refer the resolution to the CMA Board of Trustees for decision, an action which supporters claimed would allow the language to be crafted more thoughtfully.

The matter will likely be taken up during the board's January meeting and CMA staff will keep members updated on the resolution's progress.

COMING SOON!

SCMA and four other North Bay medical societies

will be unveiling a combined website in early 2013. The website, under the banner of the **NORTH BAY COUNTY MEDICAL SOCIETIES,** features a robust Physician Finder for the entire North Bay, along with a wealth of resources for physicians. Fully searchable publications for each medical society—such as *Sonoma Medicine* and *SCMA News Briefs*—are included as well. There's even an option for online dues payment and event registration.

Keep your browser posted—we're almost there!

The Giving Report

Shawn Devlin

The SCMA Alliance & Foundation had a busy and productive 2011-12 fiscal year. We raised over $100,000, all of which was donated directly back to our local community (see chart). Through a year-long granting process, the Foundation donated to many charities and organizations, including:

- California Parenting Institute, for their child abuse treatment project.
- Drug Abuse Alternatives Center, for their integrated perinatal treatment program.
- Family Services Agency, for senior counseling services.
- Hope Counseling, for therapy services for low-income children and seniors.
- LifeWorks of Sonoma County, for a school-based art therapy program.
- National Alliance on Mental Illness, Sonoma County chapter, for mental health outreach for seniors.
- Santa Rosa Community Health Centers, for postpartum depression intervention and support services.
- YWCA Sonoma County, for A Safe Place preschool mental health program.

Monies raised were also contributed to the Foundation's ongoing programs, including JourneySafe (educating teens about distracted driving), Safe Schools (anti-bullying program), Health Careers Scholarships (for students pursuing health careers) and Give-a-Gift (holiday gifts for foster children).

Who We Are

The SCMA Alliance is an all-volunteer membership organization consisting primarily of male and female spouses or partners of physicians. The organization also includes physicians and residents in training. The Alliance is dedicated to promoting health in Sonoma County through education, community service programs and advocacy.

The SCMA Alliance Foundation is the 501c3 tax-exempt fundraising subsidiary of the Alliance. Through funding community health programs and countywide fundraising events, the Foundation strives to improve the health and quality of life for the people of Sonoma County.

The 2012-13 executive board for the SCMA Alliance & Foundation includes the following officers:

- Meta Lightfoot and Shawn Devlin, co-presidents
- Janet Lakshmanan, treasurer
- Victoria Shieh, secretary
- John Gnam, past president

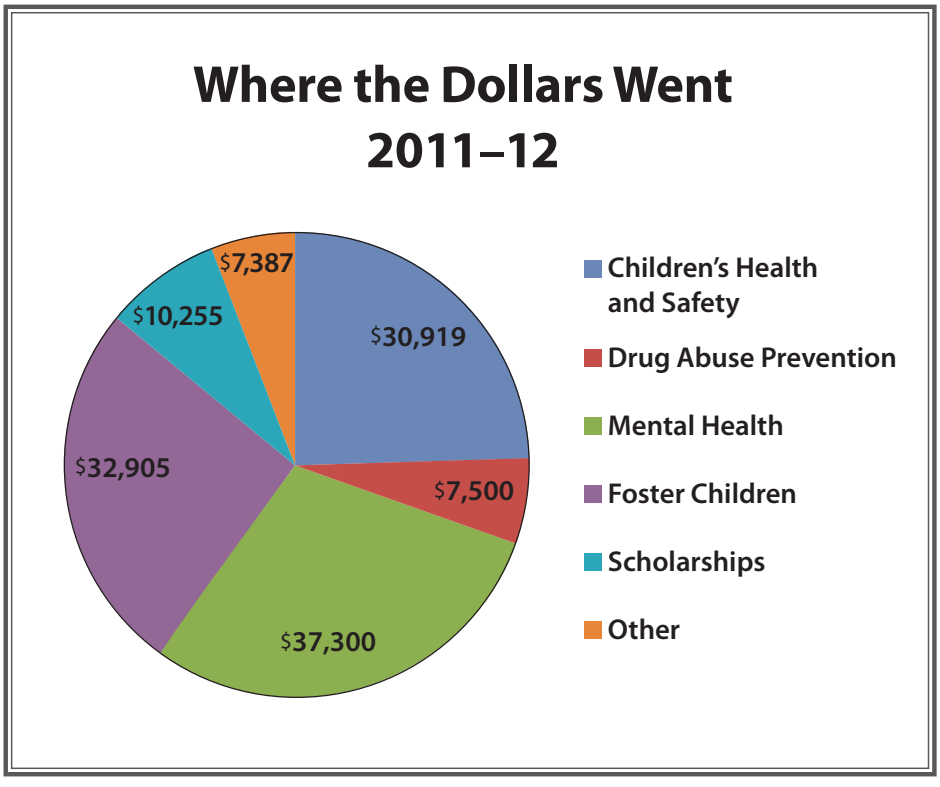
The board of directors includes Elisabeth Chicoine, Karen Erickson, Karen Hanahan, Sheela Hodes, Tricia Hunstock, Lindsay Mazur, Virginia Merwin, Barbara Ramsey, Charlene Staples and Lisa Sugarman.

The program chairs are as follows:

- Foster Children's Give-a-Gift: Shawn Devlin, Lindsay Mazur, Laura Robertson
- Garden Tour: Gail Dubinsky, MD
- Grant Review: Lisa Sugarman
- Health Careers Scholarship: Virginia Merwin
- Health Promotions: Cindy Popovich

For more information regarding the SCMA Alliance & Foundation, visit our website at www.scmaa.org. ◇

Email: scmaafpres@sonic.net



Ms. Devlin is co-president, with Meta Lightfoot, of the SCMA Alliance & Foundation.

SCMA Annual Report

Cynthia Melody, MNA

The end of the year provides an opportunity to reflect on SCMA's accomplishments in its mission to support physicians and their efforts to enhance the health of the community. The main areas of focus this past year have been on improving specialty access; strengthening the local primary care workforce through the Santa Rosa Family Medicine Residency Program; championing Health Action and its community health initiative to promote healthy behaviors and environments; and increasing access to high quality healthcare.

The recent SCMA Awards Dinner featured a Lifetime Achievement award for Dr. John Dervin; Outstanding Contribution awards for Dr. Jeff Haney, Dr. Catherine Gutfreund and Dr. Mark Netherda; and the Article of the Year award for Dr. Sanjay Dhar. In addition, the Redwood Community Health Coalition received a Recognition of Achievement award for their efforts to provide high quality healthcare. The award presentations and acceptance speeches were inspirational. For photos of the event, see pages 32–33 or visit Flickr at www.flickr.com/photos/91183744@N07.

SCMA membership continues to hold steady at 680 physicians, which is 64% of Sonoma County's practicing physicians (medical societies statewide average 36%). The Redwood Regional Medical Group and The Permanente Medical Group have made significant commitments to their group's physicians by paying their annual CMA/SCMA dues.

SCMA publications for 2012 included the monthly *News Briefs* e-newsletter, the annual *Sonoma County Physician Directory,* and seasonal issues of *Sonoma Medicine* featuring The Physician-Hospital Relationship (winter), Let Food Be Thy Medicine (spring), Muscles and Bones (summer) and Pain and Suffering (fall). SCMA also published *The Santa Rosa Reader,* Dr. Rick Flinders' anthology about the Santa Rosa Family Medicine Residency. The book is for sale at www.scma.org, local bookstores and online retailers.

Other SCMA activities during 2012 included the Wine & Cheese Reception at Williams Selyem Winery, the Residents Appreciation Dinner, and a Medical Student Social. We also conducted an Employee Wage and Benefits Survey, and 25 physicians participated in confidential peer review with CME. Legislatively, SCMA sponsored congressional and Assembly candidate interviews and coordinated meetings with our legislators in their Sacramento offices. In addition, we cosponsored many community activities, including the Future of Primary Care Conference, the Latino Health Forum, the Center for Well-Being's "Celebration of Dreams" event, Sutter's "Catwalk for a Cure" event, and several SCMA Alliance activities, such as the health careers scholarships and the Garden Tour.

One of the key SCMA benefits for member physicians and their staff is *free* legal services from attorney Larry McLaughlin. (Do you know how long you need to keep EOBs and superbills or how many years Medicare can go back to request reimbursement for overpayments?)

SCMA is also a resource for several North Bay medical societies, providing both editorial and administrative services. We have management service agreements with the Marin Medical Society and the Mendocino-Lake County Medical Society. In addition, we are facilitating a new regional website—the first of its kind in California—which includes a regional physician finder, online dues payment capability, and new physician and patient resources. Watch for it in the new year with a variety of social media portals.

The SCMA Board of Directors set a new course this fall, committing to an intensive year-long leadership coaching program to "increase SCMA physician leaders' knowledge, confidence and skills required to lead an effective and dynamic medical society." They are launching an in-depth strategic planning project in 2013, beginning with an online physician survey about SCMA and healthcare issues (participants may be eligible to win an iPad). Survey responses will help guide the board as they consider a strategic plan for 2013 and beyond.

The coming year promises to be busy. In addition to the surveys, strategic planning and new website, SCMA will be collaborating with CMA to help physicians and their staff prepare for big changes, including possible 30% Medicare cuts; the change of Medicare Administrative Contractor from Palmetto GBA to Noridian Administrative Services; a massive overhaul of Workers Comp rates and regulations; and the arrival of ICD-10 in October 2014, which will affect nearly every practice. ◇

Ms. Melody is executive director of SCMA.

Email: cmelody@scma.org

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* Physicians Insurers Association of America Risk Management Review: 2011 Edition.

**Jena et al. Research Letter, Online First: Outcomes of Medical Malpractice Litigation Against U.S. Physicians. *Archives of Internal Medicine*. May 14, 2012.

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